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HEALTH CARE FOR OLDER AMERICANS: INSURING AGAINST CATASTROPHIC LOSS

HEARINGS

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

NINETY-NINTH CONGRESS

SECOND SESSION

PART 1—FORT SMITH, AR
AUGUST 27, 1986

PART 2—LITTLE ROCK, AR
AUGUST 28, 1986

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HEALTH CARE FOR OLDER AMERICANS: INSURING AGAINST CATASTROPHIC LOSS—Part 1

WEDNESDAY, AUGUST 27, 1986

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Fort Smith, AR.

The open hearing commenced at 9:30 a.m., at the Fort Smith Sheraton Hotel, Hon. David Pryor presiding.

Present: Senator David Pryor.

Also present: Theresa M. Forster, legislative aide; Ann Pride, press secretary; and Frank Thomas, administrative aide.

OPENING STATEMENT OF SENATOR DAVID PRYOR, PRESIDING

Senator PRYOR. Ladies and gentlemen, I would like to welcome all of you this morning to this open hearing in Fort Smith, AR, of the U.S. Senate's Special Committee on Aging. Over the past year or so the areas of long-term care and catastrophic health care have received increasing attention. I believe the testimony we receive during these 2 days will be most helpful in formulating a policy for long-term health care and catastrophic coverage which is responsive to the elderly's needs. We have scheduled this meeting this morning in Fort Smith as part 1 of a 2-part hearing on this important subject. Part 2 will be held in Little Rock, AR, tomorrow afternoon. We will try to explore, through the testimony of our witnesses, many different aspects of the problem of delivering appropriate, affordable care for elderly citizens in America.

Clearly there are some very serious gaps in health care coverage for older Americans which leave the potential for financial ruin and emotional devastation. Historically, the working definition for catastrophic illness has been limited in scope. We've concentrated on illnesses which require intensive, expensive, and acute-type care. There is no question that this type of illness can cause severe financial hardships, but we are beginning to see that any condition which requires continued health care expenditures can very quickly become catastrophic.

In addition, it is becoming increasingly clear that as our population ages, the demand for long-term institutional and community based care and acute-care services for serious illnesses will only increase. Currently 1½ million Americans reside in nursing homes. By 2000 that number is expected to be 2.2 million. By 2020, 2.9 million; by 2040, 4½ million. Currently 2.1 million of the noninstitutionalized elderly need help in one or more basic physical activities

and 2.4 million elderly need the help of another person in carrying out home management activities. By the year 2020 that number may increase to more than 11 million, and by 2040 it will increase to nearly 18 million citizens.

Future advances in health technology may lengthen the lives of many more of our oldest Americans, placing additional demands on an already inadequate health care system. We must make every effort now to solve this access problem.

Over the last several years the administration has proposed that the acute catastrophic problem be dealt with through an expansion of Medicare Part A coverage, and that this expanded coverage be paid for by imposing an additional charge for all beneficiaries on each of the first 60 days of hospitalization. Congress, I must say, has resisted this proposal, primarily because it increases out-of-pocket cost to all beneficiaries who are hospitalized while helping only the very small percentage of individuals who require prolonged hospitalization.

Before becoming Secretary of Health and Human Services, Dr. Otis Bowen, who, by the way, was Governor of Indiana at the same time I had the privilege of being Governor of Arkansas, proposed an alternative approach for dealing with this type of catastrophic expense. That approach was simple, imposing a small monthly premium to cover the cost of a catastrophic Medicare policy. Secretary Bowen's proposal brought this longstanding problem to the forefront of health care considerations and precipitated widespread discussions on the catastrophic coverage issue. As part of his State of the Union Address, President Reagan directed Secretary Bowen to conduct a 1-year study on how Government and the private sector can provide catastrophic medical protection. This council has been meeting throughout the course of this year.

Only last Tuesday Secretary Bowen's Commission held its final meeting and issued a draft report [1] on its recommendations for the Secretary to consider. Secretary Bowen will meet with the President next month to review the issue and will submit his recommendation to the President by the end of this year. The Commission report has defined catastrophic illness primarily in terms of cost rather than in terms of type of illness, the intensity, or duration of a specific illness. The report states, "The economic consequences of illness become catastrophic if the out-of-pocket expenses of the individual or family, excluding expenses reimbursed by insurance, employers, and Government programs, become financially devastating."

The Commission looked at three major areas of need. First, catastrophic coverage other than long-term nursing home needs for individuals 65 and older. The Commission recommended the following options for dealing with this problem: Improving the Medicare Program to provide yearlong hospital coverage, financed through additional premiums or copayments, based on the ability to pay. Second, studying ways to expand mental health care coverage. Third, exploring voucher and other alternative health plan proposals under Medicare. And, fourth, exploring the individual medical

[1] See appendix, p. 135.

account concept. The second major area of the Bowen Commission dealt with acute catastrophic expenses for persons under 65 years of age, and the third major area catastrophic long-term health care expenses for all persons.

At this hearing this morning we will try to explore, in particular, the first and third of these areas because they are the ones that most directly affect the elderly population of our State and our country. Let us also keep in mind that the State of Arkansas is second only to the State of Florida in the percentage of citizens over the age of 60 years of age. I would, at this point, like to make the draft report of the Private-Public Sector Advisory Committee on Catastrophic Illness part of this hearing record.[2]

Also this morning we have a court reporter, a stenographer if you wish, and a full transcript of this hearing will be made and ultimately supplied to our other colleagues on the Senate Committee on Aging, in Washington, DC.

Several of the options that have been proposed in legislative form, some are quite close, I might say, to being enacted into law. It is my hope that with this hearing we will begin to gather a substantial base of information, and reactions to the committee's draft report, from which to begin our discussion on catastrophic coverage in the Congress. I look forward to the testimony that we will hear at this time.

We will, at this time, call our witnesses, but first let me introduce, for the benefit of the audience, Theresa Forster, who is on our Washington, DC, staff. She handles health care matters and problems of the elderly. Many of you who have written to Washington, your cases are dealt with by Theresa and she has done all of the preparation for this morning's hearing. Also we have two other staff here—they are trying to get the microphones fixed, so we'll introduce them later in the morning, if we could.

Let's have all the witnesses come up and take your place behind your name card, then I will introduce each of you. For today's hearing we have an excellent group of seven witnesses from this area of our State. I would like to keep our format as informal as possible, and ask that each witness try to keep his or her testimony to between 5 and 7 minutes. If you have any additional written comments or supporting materials, I would like the witnesses to submit these comments and material for the public record.

First we have Jim Medley; he is the good-looking fellow with the red tie, to my far right over here. Jim Medley is no stranger to this part of our State. He is the executive director of the Area Agency on Aging of Western Arkansas. Jim has testified a number of times before different congressional committees and always has been very thoughtful in his testimony. We're very happy to have him with us today. He will be representing the concerns of the Arkansas Home Health Association, of which he is the current president.

Next we have Nelma Bennett. Nelma Bennett is a registered nurse with the Western Arkansas Area Agency on Aging. Nelma has worked with the agency for 3½ years. She is the area supervi-

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[2] See appendix, p. 135.

sor for personal and in-home care services in Logan and Franklin Counties.

Then we have Mrs. Sarah Lovett, of Greenwood. She has some very interesting and poignant testimony to share with us today about her husband's need for nonacute long-term care. We would particularly like to thank her for coming here today to share that story with us.

Mr. Sam Hocutt, of Hot Springs. He has come a fairly good distance today to be with us; has made a great sacrifice to do that. He will be telling us of his family's difficulties in trying to ensure that his mother and father receive appropriate care. We are very grateful to Sam for coming all the way here and contributing to this hearing record that we will be taking back to Washington, DC.

Dr. Pat Phillips, of Fort Smith, is here today at the request of Dr. Ken Lilly, the president of the Arkansas Medical Society. He is also a member of the National Legislation Committee of the Arkansas Medical Society. I know he will present some very thoughtful testimony and we are grateful to Dr. Lilly for allowing and encouraging Dr. Phillips to testify. Dr. Phillips, we welcome you to this hearing.

We would also like to welcome Jim McDonald, president of the Arkansas Hospice Association. Jim has come all the way down from Fayetteville to be with us today. He is the director of the Washington Regional Medical Center Hospice. We welcome his presentation this morning.

Finally, we have Bob Lane, the national committeeman for the Arkansas State Association of Life Underwriters. We're going to try to get perspective from the insurance industry on this very major problem of catastrophic health insurance. Bob acts as a liaison between the Arkansas Life Underwriters Association and the national group in Washington, and has been active in the insurance field for 21 years. He is well acquainted with some of the problems associated with developing insurance for catastrophic and long-term care coverage, and we really appreciate him coming and representing his organizations.

At this time, we will turn the microphone over to Mr. Jim Medley for his statement. I think we will allow each of you to make your statements and then once the statements have been made—rather than interrupting as we go forward—once all statements have been made we will ask some questions. Thank you, very much, and you may proceed.

STATEMENT OF JIM MEDLEY, FORT SMITH, AR, PRESIDENT, ARKANSAS HOME HEALTH ASSOCIATION

Mr. MEDLEY. Senator Pryor, thank you for allowing me this opportunity to testify. My name is Jim Medley and I am executive director of the Area Agency on Aging of Western Arkansas. Today I am testifying as president of the Arkansas Home Health Association.

We are all here today to discuss what can be done about the problems our elderly are experiencing through high medical costs, especially those associated with catastrophic illness. Catastrophic illness is an illness of major proportions that causes a permanent

change in a person's lifestyle. Quite often a catastrophic illness is of sudden onset and elderly individuals, who feel that they are well covered by Medicare and supplemental insurance, find themselves either owing large amounts of money or are unable to obtain the service they so desperately need.

In order to illustrate the problems, I would like to describe a typical elderly person and the problems he or she may encounter with a bout of illness. The first concern for Medicare patients who are suddenly hospitalized is the payment of an ever-increasing deductible. Many elderly live barely above the Social Security supplemental incomes, with a monthly income of less than $500. These people are generally unable to save enough money to meet this deductible even once during the year and they can be required to meet it as many as four times in 1 year. Many of the better supplements cover the deductible but the cost of these supplements can be from $60 to $100 each month. Once the patient is hospitalized for a major illness, he is often referred to a specialist for diagnoses and treatment. Even if the patient has been careful to obtain an attending physician who takes Medicare assignment, the specialist may not do so. And the elderly, ill, individual may be in no position to shop around for a specialist.

We are all familiar with the concerns over length of stay being determined by the diagnostic related groupings, commonly referred to as DRG's, rather than the patient needs. I will cite several examples we have encountered of specific cases where patients appear to have been discharged in such a weakened state that they became worse and had to be rehospitalized. We feel that Congress has already made some progress in demanding quality assurance in the form of better notification of determination of coverage and rights of appeal for inpatients.

Once the patient is discharged the coverage problems with Medicare become much greater. For example, it is not uncommon in our experience for a patient to require medication prescriptions costing well over $150 each month during a catastrophic illness. We have many elderly individuals who simply do not take their medication, take only some, or reduce the dosage themselves, because they cannot afford the medication. My nurses report that lack of coverage for medications in home care is a primary reason for hospitalization among our elderly. We have seen patients, for example, who were discharged after hospitalization for a stroke, and report to us that they are being treated for hypertension but just couldn't afford the pills so they were going to cut them in half themselves.

As a provider of home health care to elderly Medicare patients, we are in a position to cite many examples of areas where more coverage was needed. Medicare says Medicare covers home health visits at 100 percent. This is a quote from the Social Security Administration literature, which sounds good, but Medicare covers the visits that they deem necessary; there are restrictions. One of the major limits is a requirement that care be intermittent. The Health Care Financing Administration, commonly referred to as HCFA, has interpreted this to mean that daily care will be covered for a very short period only; for example, 10 days. Even though the nurse may be present for only 1 hour a day, Medicare claims that the care is constant.

Another concern in this area is the situation of a person who can afford to hire an attendant. Now, the patient must prove the attendant does not provide medical care, because if they don't prove this the Medicare benefits are denied because HCFA says they are receiving constant care, even though Medicare is not paying for the care giver. Medicare requires that the person receiving care be homebound. The lack of a good definition of that term is also a problem. Many persons who would feel better if they were able to get out of the home briefly are afraid to do so because they may lose benefits. It would be easier for a patient with severe respiratory and cardiac problems to be driven, with their portable oxygen, to a nearby air-conditioned restaurant for breakfast, by a friend or a relative; however, if they do this then they are not considered homebound. Certainly removing them from the heat of the kitchen, or smoke, or so forth that goes along with this, could help them avoid respiratory distress.

The method of payment of home health claims sometimes causes the elderly to be denied service. Medicare holds each agency responsible to understand what services are covered. Since coverage is a complicated matter that is open to more than one interpretation it is not easy to determine. Nevertheless a home health agency must decide, without assistance, if it will cover care or not. Only after the care is provided and billed will the agency know if the care will be paid. There is no limit on the amount of time that may elapse before a final decision is made. Is it any wonder that many agencies are refusing to serve those persons who may not be covered? In other words, borderline cases lots of times are being turned down. Often the agency does not make clear that they have made the decision not to take the risk and that another agency might be willing to try to bill. The patient is just told Medicare does not cover this service.

There are needed services that Medicare does not cover. I would like to cite some examples from this area. Now, I have some cases here from our files and in order to maintain the confidentiality I'll refer to these people by their initials rather than their names. Mrs. I.J. is a 59-year-old disabled woman with heart problems. She has an ulcer on her leg which does not heal because when it improves Medicare denies services and it gets worse. Mr. J.T. is a 48-year-old paraplegic who has a decubitus on his tail bone, because he could not reach the area to dress it. Medicare denied this saying that the nurse should have taught him to do self-care. Mrs. T.G. is a 77-year-old person with terminal liver disease and cardiac problems requiring pacemaker insertion, and was discharged from the hospital too weak to do self-care. Medicare aid service was available only as visits and there was not enough time allowed to do all the care that was necessary. She was soon readmitted to the hospital in a worsened condition. Mrs. C.B. is an 84-year-old diabetic. Her doctor requested blood sugar be drawn every 2 months. Mrs. B. is unable to leave her home. Medicare denied service saying that insulin dosage is not changed often enough to show that blood sugar results are used in patient care. Mr. S.G. is a 47-year-old heart patient who is attempting to raise money for surgery. He feels it is necessary to attend some of the fundraising events to thank the people who are helping him; not only does Medicare not pay for

this type of surgery, but since he is not homebound he cannot receive nurse visits at his home. Mrs. O.B. is an 83-year-old with heart and vascular disease, diabetes, and eye problems requiring surgery. She is too weak to adequately care for herself. Care was denied as custodial; in other words, not requiring the care of a skilled nurse. Mrs. E.B., who is 63, and there are others like her too numerous to list—Medicare regulations require outpatient surgery for cataract removal. Postoperative drops are required four times per day for several days. Due to shaking Mrs. B. cannot adequately drop medication into her eye. Medicare allows one nurse visit per day for 10 days, postsurgery, but what about the other three times a day her medicine is needed. Mr. C.H. is a 70-year-old postcolostomy, paraplegic, with bladder catheter. He has a 1½-inch deep decubitus on his tail bone and is very weak. The nurse requested that his doctor hospitalize the patient as even maximum home health hours under Medicare are not providing enough care. His doctor denies hospitalization saying that Medicare won't pay for more time in the hospital. Mr. H. does not qualify for nursing home care under Medicare. Mrs. A.H. is an 84-year-old with pernicious anemia, on potassium depleting medication, diabetic, unstable blood pressure. Medicare denies all visits but one per month, based on the need for the B_{12}, for pernicious anemia, being covered as once per month only; the other diagnosis are not taken into consideration.

Catastrophic illness often requires long-term care for which there is essentially no Medicare coverage, and until recently very little private coverage could be purchased. Unfortunately, many elderly are unaware that Medicare does not pay for the nursing home care most people need, or other forms of long-term care, until the need arises. We have addressed two different issues in our examples; one concerns the overall cost of Medicare and restrictions aimed at limiting this cost, such as increasing deductibles and the DRG's. The impact of these measures need, of course, to be carefully studied and evaluated. The other issue is more subtle, less easily monitored and evaluated, that is the interpretation by HCFA of the regulations which govern care in such a way as to decrease service.

I hope the examples I have cited have illustrated ways in which we, as home care providers, see some of the current interpretations as being harmful to the patients' health and safety. Thank you, Senator Pryor.

Senator PRYOR. Jim, thank you. Shortly when all the panelists have finished their statements, we will be directing some questions to you.

Nelma Bennett, we appreciate you being here and look forward to your statement.

STATEMENT OF NELMA BENNETT, R.N., PARIS, AR, LOGAN COUNTY NURSING SUPERVISOR, AREA AGENCY ON AGING OF WESTERN ARKANSAS

Ms. BENNETT. My name is Nelma Bennett and I'm the Logan County nursing supervisor of the Area Agency on Aging of Western Arkansas.

I have one particular case in mind, since it involved five elderly people who were brothers and one sister, in a rural community. Our referral nurse was unable to provide the much needed assistance with personal care or the provision of an aide to plan and prepare meals, as three of these elderly people were diagnosed with mental retardation, two with muscular dystrophy; neither one of the diagnoses were acute.

These people were eating off of broken dishes. They were living in very unsanitary conditions. They had a small amount of money in their bank account. Medicare was the only medical help that they were receiving. Since the money was in their bank account they were unable to be eligible for Medicaid. After some time and after the death of their guardian they were able to apply for Medicaid. They used their bank account to put money back for their burial. They were able to buy new dishes to replace the broken ones. During the time they were on Medicare only, their friends and neighbors, people in the community, tried to provide all the assistance that they could. These people were unable to ask questions and get the help that they needed. The Medicare did not provide the assistance that they needed, not covering staying in their own home and having an aide come in to help with their personal care. Thank you.

Senator PRYOR. Thank you, Nelma. We will also be coming with a few questions for you in a few moments.

Sarah Lovett, from Greenwood, will testify about her husband's need for nonacute long-term care. We are certainly proud that you have come to be with us today, Mrs. Lovett.

STATEMENT OF SARAH LOVETT, GREENWOOD, AR

Mrs. LOVETT. Thank you, Senator Pryor, for this opportunity. My husband is an Alzheimer's victim. It all started in 1971 when he was 56 years old and has been a very stressful 16 years, for me especially, for after the initial beginning of the disease Stanley did not realize what was happening to him. But for me the years of searching for help through clinics and doctors to alleviate his memory problem, with no real answers until 1979 has been very stressful.

He was a minister in San Antonio, TX, under a large workload at home, 5 months of the year in meetings all over the Nation, and an editor of a national religious magazine. So loss of memory was naturally frustrating for someone in his profession. Doctors in the physicians clinic, in Houston, diagnosed his problem as probably depression due to early hardening of the arteries. After moving to Fort Smith in 1973, upon a doctor's recommendation to preach for a small church, hoping that if it was depression this would help, he was happy from that time on and was perfectly oblivious of his problem. He had a storehouse of knowledge on paper, so could take an outline to the pulpit, which he never did before, and deliver a lesson.

Disorientation took over though and total disability was taken in 1977. It has been hard to watch his bright mind slowly deteriorate, becoming a different person entirely; eventually not knowing us at all. By 1979 he was becoming psychotic also and did dangerous

things before I realized just how bad he was. I did not want to accept the reality of it. He shot a hole in the wall while cleaning a loaded gun. Needless to say, I hid the guns. In looking back I can't believe that I had not done it before. He played with fire. We saw signs of this and saw him light a rolled up newspaper, burn it, and then throw it on the floor to stomp it out when I asked, "What in the world are you doing?" He carried a hammer around saying that he would certainly never hurt anyone, but when we would hide it he would manage to find it. He would drink liquid of any kind if he wasn't watched, and run away if we weren't watching.

He was hospitalized then in 1979 for reevaluation, and was diagnosed as Alzheimer's, and medication then relieved some of the psychotic tendencies. Suffice it to say, he needed 24-hour supervision. So I retired from teaching as the elderly lady that kept him while I taught could not handle the situation when he became incontinent and I could not find anyone who would. I retired too early. If I could have had help in the form of day care centers, or sitters at home, in order to continue teaching, it would have helped me to better cope. Why not a nursing home at this point, which my family and doctors both recommended? For two reasons: No. 1, I wanted to be the one to care for him at home. He didn't really know me except for brief moments—very brief moments, at times I could see recognition in his eyes; he knew I was someone who loved him and cared for him and he clung to me and depended upon me. No. 2, I did not want to use all our life savings, was the second reason.

Three years ago he lost his equilibrium and could not walk without my help. He was hospitalized with a head injury after getting out of bed and falling against a dresser. Since then he has been a complete bed patient. How much home health help have I had? Much of the time, none. After a hospital stay, only a while, because they said his condition could not be improved; so I had no help. After a Foley catheter was prescribed a year and a half ago, I again qualified for home health help. I could have learned the catheter care myself, because I was already catheterizing him every 6 hours. But I was grateful for the aides that this enabled me to have because I desperately needed them. I might say here that 2 hours, three times a week is not enough help to care for someone in his condition who has to have 24-hour supervision and care, but it is all that I have.

I don't know what I would have done without the help of family, church members, friends, and neighbors; they have all helped me to keep my sanity. I had sitters also at times, even some for 2- or 3-day trips to go see my children and family, but this is so expensive and I have tried to live on our Social Security since the future is so uncertain. This summer I was without an aide several weeks because it is hard to get them to come to Greenwood. If car expenses could be paid to encourage aides to go to small towns in rural areas it would help. My 19-year-old granddaughter lived with me then and was a great help.

Another thing that has been a big help, a very big help last summer for a while, was the fact that I was lucky enough to be chosen to be the recipient of help from Homemaker Home Health, an experimental project the State and Federal Government was

doing to see if it would save the Government money by trying to keep more people out of rest homes. They examined our Social Security income and determined that I pay only $1.30 an hour and they would pay the rest for aides. I was told that I could have as many as 100 hours a month, but this did not materialize because of a shortage of aides. I was going to work some if it had. I had two 6-hour days and one 3-hour day a week. This gave me time away which I needed so much and relieved the tension. I was cut off however about 6 or 8 months before this program ended; they were short of aides. The State wouldn't train more and they said to me that someone else needed my aide worse than I did. I highly recommend this program be implemented by the government for people in my position.

I might could have gone on longer, who knows? But now I have finally agreed with my children and everyone else, that I have gone as far as I should emotionally and physically. It is becoming very hard; he needs skilled care, will need it more and more, and I don't think he will even realize he has been moved. He does not speak a word and doesn't respond in any way. He has to have everything done for him.

My biggest problem now since I have reached this decision and given in to putting my name on a waiting list at the only Medicare approved home in the area, is getting him in. They called to say that they had a room and my insurance would pay up to a year if Medicare would pay 20 days, but he has to enter the hospital and be there 3 days and then has to enter the nursing home 3 days after the hospital. He does have a chronic urinary infection all the time, but it is not acute at this time, so the doctor cannot enter him in the hospital. So if he cannot enter the hospital, I cannot have this year paid for in the nursing home. We tried to find out if I would pay for the 3 days in the hospital, if Medicare would then pay for the nursing home and my doctor called Little Rock to try to find this out, but they had no answers. They say Medicare changes so often they do not know what the help could be; no one can give any answers.

If I could have this 1 year paid for I would rest, regroup my life, and in some way become a wage earner when this year is up so that I could pay for his care then. I think they would still hire substitute teachers at 68. But $3,000 or $4,000 for the first 3 days in the hospital and then the 2 or 3 months to wait to see if they pay the nursing home would be $6,000 or $8,000 out of my savings. This is my problem. Thank you Senator Pryor and God bless you for addressing this problem for me and all others in my shoes.

Senator PRYOR. Mrs. Lovett, thank you for coming and sharing your problem with us, with this audience, and ultimately with the Senate Committee on the Aging, because I think you probably speak for thousands of Americans just like you, in your situation, and this is exactly why we are gathering this type of information today so that we can find a solution for the Mrs. Lovetts of the world. I know that almost daily in our office in Washington we receive letters and inquiries about finding answers and solutions to some of these types of problems, and hopefully this hearing will ultimately find some of those solutions. In a moment I may ask you a question or two.

Mr. Sam Hocutt, of Hot Springs, has come today to tell about his family's difficulties in trying to ensure that his mother and father receive appropriate care.

STATEMENT OF SAM HOCUTT, HOT SPRINGS, AR

Mr. HOCUTT. Thank you, very much, Senator Pryor. On behalf of my family and my mother, I would like to thank you for the opportunity to allow us to share our comments with you. My name is Sam Hocutt. I am a senior sales engineer for Honeywell. I reside along with my wife, in Hot Springs, AR, with our new daughter, an exchange student from Norway, that we're real glad to have.

If I were to attempt to place a title on my comments this morning it would be those who fall through the cracks. My father suffers from Parkinson's disease. My mother, at age 82, in excellent health had been taking care of my father. She suffered a catastrophic massive stroke a year ago next month that left her paralyzed on her left side totally. The only use she has of her physical body is that of her right arm and hand, and she can move her hand in about an 18-inch radius circle. This allows her to feed herself with her right hand. She cannot walk, she cannot stand, she is bedridden, she requires care from someone to transfer here from the bed to a wheelchair, a wheelchair to a porta-potty for all hygenic functions, bathing and so forth. The positive thing—if you look around you can always find somebody worse off than you are. The positive thing of her situation is, Senator, she still has her mental faculties about her.

She was in intensive care in a hospital in Birmingham, AL, for some 15 days, transferred to a rehabilitation hospital there that provided excellent care for her condition. The hospital, in intensive care and the rehabilitation hospital, as the system is structured only allows for care that is classified as reversible care, reversible illness or reversible affliction, as opposed to irreversible illness or affliction. Once the rehabilitation hospital, after some 17 weeks of treatment, funded by Medicare, decided that her illness or her affliction was no longer treatable, naturally she was discharged. That left us in a dilemma then.

What do we do with an 82-year-old mother, that you love, a father suffering from Parkinson's disease that cannot be left unattended? He has mental lapses. He is apt to walk off. You have to see that he takes his medicine, see that he eats; it is like caring for about a 3-year-old child.

What do you do? We looked at the various resources available in the Birmingham area. Our perception is that we did not find a health care facility structured to give my mother the skilled nursing care that she requires to sustain life. Second, if we had found one, there is a gap between Medicare coverage because she has an irreversible illiness, an affliction, that she will live with the balance of her life. We found the gap in the coverage.

I came back home and I examined the Little Rock area and the Hot Springs area, and I found some private facilities that could provide the care that they need, at our expense, but with a waiting list a mile long.

Now, what did we do? We elected—I have a widowed sister who has moved in with my parents and between my widowed sister and another sister and her husband, schoolteachers, who live next door to them, we are providing the around-the-clock care. I feel for my friend on the right, here, because I know what she is talking about. We are providing the around-the-clock care required for my mother and my father, with three people, two of whom have to work to make a living. Now, this is very straining, not only physically but emotionally, to provide the acute care-type of care that is required for my mother to sustain life. One might say, "Well, why don't you put her in a convalescent home?" We looked at convalescent homes. She falls in the crack between the kind of care one can receive in a rehabilitation-type hospital, or hospital structured to treat reversible afflictions versus the kind that my dad can receive, because he can walk, he can dress himself, he can feed himself, but you kind of have to guard him. There's a gap—there's a crack.

The system as it is structured doesn't provide this accommodation. I met with many of my fellow friends in the health care industry across the State and I find out that due to certain governmental regulations they would build structures or provide structures for people who fall through the crack, but because of an allocation of beds for health care facilities, they cannot take the beds away from the ones right now. For instance, in Pulaski County there is an abundance; there is a surplus of nursing home facilities, skilled nursing care beds going unused, but because of the allocation requirement they can't be transferred to a facility that would provide the acute care-type treatment, either private or Medicare get-in-line funded, that my mother needs to sustain life.

A summary of where we are at; every chance I get—I took a week's vacation 3 weeks ago and went down just to relieve my sisters, so they could catch their breath. So I know what you're talking about. We don't see a light at the end of the tunnel.

In our business we abhor someone who says, "Hey, here's a problem," you know, offer something to contribute to the problem. Well, what would I offer? If we could change the regulations concerning the allocation of the skilled nursing care beds to where the surplus could be used in a more constructive, positive manner, so that people like my mother could find a place that she could be cared for, if that's what we elected to do. We fall through the gap.

In the State of Arkansas, one must use one's resources up—find out—to a point of $2,500 in assets before you qualified to receive any additional supplemental care, or funding of the care that is required. In 1 year we have spent approximately $25,000 of my mother and father's assets to see that they are taken care of. She is now 83; she's holding her own and she could live 5 more years; she could live 10 more years. With the assets they have, in about 4 years we've got a problem.

This, Senator, to me is gross discrimination between those of us who, like yourself, like all of us in here, have worked all these years—I turned 55 last week and I'm now a senior citizen—who have worked and paid taxes and supported the system all these years, to know that if we need help we have to become paupers, or in Arkansas reduce our assets down to $2,500; that's discrimination.

In closing, I would say that my perception is we need to arrive at a national health care policy, not only that covers and encompasses the entire aspect of care for the aged, but especially those who fall through the cracks, like my mother. If we can place a man on the moon, because President Kennedy prioritized and said, "We're going to make that happen," then I say and submit for this hearing, that we have a societal need to provide for care for ourselves. In order to accomplish this we need to prioritize and come up with a plan of what kind of track are we going to try to run the train down; establish this as a priority based on the resources that we have in this country and get on with implementing this plan. Thank you, very much.

Senator PRYOR. Sam, thank you very, very much. Once again, I think you have expressed a concern on behalf of thousands, and perhaps hundreds of thousands, of Americans in a very similar situation to yourself.

Dr. Pat Phillips, of Fort Smith. He is a member of the council of the Arkansas Medical Society. He is also a member of the National Legislation Committee for the Arkansas Medical Society, and for him to come and give of his busy day today, we're very, very grateful and appreciative. Dr. Pat Phillips.

STATEMENT OF PAT PHILLIPS, M.D., FORT SMITH, AR, COUNCIL MEMBER, 10TH DISTRICT, ARKANSAS MEDICAL SOCIETY

Dr. PHILLIPS. Senator Pryor, Ms. Forster, Ms. Pride, members of the panel and attendees, my name is Pat Phillips and I am a practicing gynecologist in Fort Smith. I am here representing the Arkansas Medical Society; the views I express are my own.

My father is 85 years old. He is cared for at home by my mother. My father-in-law died 2 years ago after being confined 5 years at home on 24-hour-a-day oxygen, cared for by my mother-in-law. I'm not insensitive to the problems I have heard expressed here today. I speak in support of catastrophic coverage for health care, not just for the elderly but all Americans. The goal of catastrophic coverage is not debatable; the methods of obtaining that goal surely are.

First, may I make some comments to define the problem. It is important to define this proposed coverage into acute care and long term or chronic or custodial care, because they present to us two very different problems. Some 30 million Americans are Medicare recipients, according to congressional figures and less than 300,000 are hospitalized more than 60 days and lose full hospital coverage, and less than 12,000 beyond 150 days when all Medicare coverage ceases.

I have personally reviewed the admissions at Sparks Regional Medical Center for the last 18 months, and 7,200 Medicare patients were admitted during this timeframe. Only 48 patients were hospitalized longer than 60 days, and only 2 patients longer than 150 days. And virtually all of these patients were chronic, obstructive, pulmonary disease, such as my father-in-law, renal dialysis patients, or cancer patients. This calculates to approximately 7 per 1,000 patients who exceed their full Medicare coverage; a figure remarkably similar to that cited from congressional sources. This would indicate that this area is a microcosm of the entire Nation

and that the estimate that less than 1 percent of the elderly will need catastrophic acute care coverage in any one year is accurate. Some 70 percent of Medicare patients are covered by some form of Medi-Gap insurance that insures against this acute loss, another 15 percent are covered by Medicaid; thus we have about 20 percent who cannot afford or who do not obtain additional coverage, and they face the potential of acute catastrophic loss.

Therefore, Secretary Bowen's suggested plan to cover all Medicare recipients by an additional charge per month, which would add $5 billion to a system that is now under severe financial strain, does not appear to me to be a wise course. I do not believe it would be appropriate to create another level of administration in the Medicare Program. Surely, acute-care coverage now at risk can be accomplished by not dismantling an efficient private system, yet, creating a fiscally sound program with coverage for all beneficiaries.

Now to the problem of long-term, chronic, or custodial care; a much more complex and multifaceted problem. The best available estimates are that we have 1.5 million elderly now in nursing homes. But another 5 million being cared for at home by relatives and others. The costs of current nursing home care defy accurate analysis, but $60 million a year is one estimate. The value of care given at home is impossible to calculate. The need for assuring coverage for long-term care is unquestioned. This type of care can and often does generate catastrophic expenses, however, at this time we have no clear understanding of the requirements of such care, the enormous cost involved, and just what should the role of the Government play in this area. It should be obvious to anyone that expanding coverage in custodial care will result in an unknown but significant shift to any public program of the 5 million being cared for at home by spouses, relatives, and friends. I have absolutely no confidence in any current cost estimates you can make about such a program. The End-Stage Renal Disease Program was estimated to cost $100 million per year, maximum; this past year it cost 20 times that amount.

We all hear anecdotal stories of individuals where chronic disease has taken their health, their life savings, and their dignity. This enormous problem deserves our serious study and an ultimate solution. However, we must answer questions. When does coverage begin? What is to be covered? Where does the revenue come from? How are we going to allot our national resources? We are in a sense seeing a result of better and increased care to our elderly. The older and more frail of our population have increased enormously and they show no sign of decreasing. Just the expected aging of our population, particularly in the over-80 age group, will markedly increase the need for long-term care in the coming years. Our current health system is poorly designed to meet the needs of an aging population. It is not just a question of more services, perhaps, the emphasis must be on different services, away from nursing homes into home health care, into considerations of the quality of life; difficult questions, no easy answers.

In summary, it is my belief the elderly, as well as all of our people, should have protection from catastrophic financial consequences of illness. While the number may be small in relation to

total population, all of us are at risk and the impact on those faced with catastrophic cost is devastating.

Acute-care coverage is more definable, more predictable, and more affordable, and should be implemented at once, for all, without delay. A combination of the private and public sector should be used and this protection should be afforded to anyone unable to pay for it, for the poor and low-income person additional Government resources are necessary. For those currently covered by private means, such acute care coverage should be encouraged and expanded. We can ill afford in this Nation any new universal program which covers those not in need; remember there is no free lunch, the revenue must come from somewhere. But to long-term care, it is extremely complex. It should be studied, analyzed, and hopefully solved, and in my belief independent of delivery of acute care. Preservation of the family unit, some new and innovative solutions to the problems of expanded age population and a coordinated public and private sector approach to extend, improve, and pay for long-term care are sorely needed. Thank you.

Senator PRYOR. Dr. Pat Phillips, we thank you, and we certainly appreciate you giving time out of your busy day to make this contribution to this hearing.

Jim McDonald. Jim is president of the Arkansas Hospice Association. He has come from Fayetteville to be with us. Jim, we welcome you. And, first, I hope that you will, in one paragraph, tell our audience what the hospice association is and then take your testimony from there, if you would.

STATEMENT OF JAMES McDONALD, FAYETTEVILLE, AR, PRESIDENT, ARKANSAS HOSPICE ASSOCIATION

Mr. MCDONALD. OK. Thank you, very much, Senator Pryor, for this opportunity to be here. As you mentioned I'm president of the State Hospice Association. The State Hospice Association is an organization for hospice programs in this State, to encourage the development of services for terminally ill patients. Hospice programs provide a comprehensive service designed to assist families in caring for patients at home. Patients qualifying under Medicare for hospice must have a prognosis of less than 6 months.

Issues raised here have been, to this point, I think, the same issues that we face in hospice to some extent. We're trying to look at providing care for patients that fall through the cracks; those patients that do not have a skilled nursing need as defined by Medicare for home health, or those patients that do not have a prognosis that is clearly definable as less than 6 months. Hospice has some advantages over home health in that we do not have the strict requirements for skilled nursing visits threatening us for denial of the care we provide.

In many ways hospice care is preventive medicine for terminally ill patients; that sounds ironic. But what we are able to do with hospice is assess patients' needs and provide intervention before they become critical issues that require hospitalization; something much needed in home health care, but not allowed. Where we wind up with problems is that patients are referred to our program that have a chronic disease; but they do not have a prognosis of less

than 6 months. Also, nursing homes are utilized to provide care for patients without adequate care givers, homes, and yet, nursing homes are not specializing in providing care for terminally ill patients. They are providing care for patients that have custodial needs.

Many hospice programs across the country have moved into the nursing homes and helped to provide that specialized care, skilled assessment and management of pain and other symptoms that terminally ill patients face. Providing that assessment and intervention, helps to break the cycle of going to the nursing home when the symptoms are under control and then when the symptoms become out of control, shipping the patient back into the hospital. Then, once the symptoms are again under control, and the DRG's are beginning to run out, the patient is put back into the nursing home. This is a never-ending battle of shipping patients back and forth because of the way the reimbursement system is set up.

Nursing homes are funded primarily by Medicaid, that's a needs program, which has been discussed already. Medicare provides coverage for hospice. This last month the Medicare Administration has issued the ruling saying that Medicaid patients are not eligible for Medicare hospice coverage when they are in a nursing home. The nursing home has become their place of residence but it is not considered that under the recent Medicare ruling. It is now considered a duplication of services and this concerns me. The same logic has been applied to home health to deny eligibility to patients. If the home health patient has a hired care giver and that care giver is providing assistance with medications, if that care giver is providing some medical assistance, it does not qualify them to the skilled nurse to assess that patient's needs, yet that patient is denied home health services. It's the assessment of the continued support of the hospice nurse or the home health nurse that is able to help prevent patients from waiting until problems become acute symptoms, as defined by Medicare, that require in-patient admission.

If we can approach the issues that face these patients in their homes we can cut down the cost of the care provided, by eliminating the repeated use of hospitalization. Not only do we look at that from an issue of costs, but from the perspective of patient and family. The emotional drain on the family and the physical discomfort required to ship the patient back and forth are serious considerations.

Medicare hospice does allow for respite care. It is the only time Medicare will pay for in-patient care in order to give the family a rest. Medicare does not allow for respite care in the home; the goal of hospice is to help provide that respite in the home. So if Medicare is to pay for hospitalization, to give 24 hours, 48, or 72 hours of rest to the family, it would be more appropriate and more in line with the hospice philosophy of care to provide that same 24-hour coverage in the home for those periods of respite.

One other issue which faces hospice programs in this country has to do with the inconsistencies by which the Medicare hospice benefit is reimbursed in hospice programs. I serve on the Licensure and Reimbursement Committee for the National Hospice Organization and I also serve on the Council of State Organizations for the Hos-

pice Organization. One of the issues that has come to our attention repeatedly is that the intermediaries who are interpreting Medicare guidelines for hospice vary from State to State, and from intermediary to intermediary, so that reimbursement varies tremendously, based on interpretation of what is covered under the hospice benefit and what is not. That's one issue that I don't think I need to go into detail, but just to note at this point. Thank you.

Senator PRYOR. Jim, thank you.

Now, our final panelist is our friend Mr. Bob Lane, representing the Arkansas State Association of Life Underwriters. We're going to get a perspective from the insurance companies' point of view. Bob, we look forward to your statement. If you could, Bob, hold this to about 5 minutes then we're going to start asking some questions. Thank you.

STATEMENT OF ROBERT T. LANE, CLU, CHFC, FORT SMITH, AR, NATIONAL COMMITTEEMAN, ARKANSAS STATE ASSOCIATION OF LIFE UNDERWRITERS

Mr. LANE. I can sure do that. Let me tell you first that I'm not in insurance management. I'm a salesman, and I have been for 21 years, so I don't represent probably the managerial aspect of developing policies and marketing concepts. I sell what we have in the field available, and sometimes I think the home office people have no regard for the field, as far as what we know we need and what we know people need and will buy.

Insurance people are conservative by nature. I know very few liberal insurance people, and I work with them in a personal and professional capacity on a local, State, and national level. Insurance people are sales oriented, they are commission driven, and they have a different outlook, I think, than maybe a lot of people who punch a timeclock everyday and know what the check is going to be cut for on Friday afternoon. As a whole, I would say the insurance industry feels that primarily the responsibility for taking care of yourself and your loved ones is the individual's responsibility, with the individual's money. For those people who are unwilling—not unwilling, unable to help themselves, we certainly realize that there is some combination of the public and private sector that must be utilized to take care of these people.

I agree, in essence, with what Dr. Phillips said, it would be great to have an all encompassing, federally proposed, federally mandated, long term and catastrophic care program for everybody in the United States, but we can't afford it. It is just that simple, we cannot afford it. People who are paying taxes cannot afford to carry those people who could buy insurance themselves.

I've got a quote here I would like to read to you, from one of your people in Congress, Representative Roybal, chairman of the House Select Committee on Aging, has proposed the U.S. Health Act of 1986, to include for everybody in-patient and out-patient hospital services, preventive care, physician coverages, laboratory and x-ray services, prescription drugs, nursing home, and home health services, in-patient psychiatric hospital services, basic dental care, and vision care. This Representative is quoted as saying that Americans find it unacceptable that over 30 million people have no

health insurance protection. A lot of people in America have no health insurance protection because these people don't place a high enough priority on insuring against catastrophic illness or death; they spend their money in other areas. I talk to these people every week. It is just not that important to them. I'll admit, with anybody, that it is hard paying premiums, but it is a lot harder paying doctors and hospital bills; believe me. I buy insurance and I sell it and I use insurance; I'm clumsy.

What is catastrophic, by definition? Is catastrophic no money at all to be paid by the individual, is that catastrophic to you all? You know, how long is a row? We have catastrophic insurance available today in the United States. It's called the good, comprehensive, major medical insurance policy. You pay a deductible of $100 to $1,000, the insurance company then pays 80 percent, generally, of the first $2,500, or $3,000, or $4,000, or $5,000 of usual, customary, and reasonable expenses, and then after that for the rest of that calendar year it goes to 100 percent, with $1 million lifetime maximum. That's comprehensive catastrophic insurance to me, and to those people who see fit to seek out an insurance person and buy the coverage.

We don't have the answer for long-term care. I've got some data I'm going to turn over to Senator Pryor for his committee's use, he may have some of it, he may not, but I won't go into it. I'll say basically though that the National Association of Life Underwriters understands, like you do, that we've got a problem, that we've got to work on it. Some of it we cannot resolve by ourselves. It is going to take an expansion of the public sector and taxpayers money. We accept that fact. We also ask at the same time though that the Federal Government get some of the fingers out of the pie and concentrate their resources and get some people finding out where is the stress, the strain, the fat, the extraneous.

Why are we insuring people who are relatively wealthy and don't need it. We're devoting a lot of our taxpayer dollars to people in America who don't need to be helped. We need to let those people help themselves. We need to let everybody, to the extent possible, help themselves and then concentrate, all of us, on those people who can't help themselves that desperately need our help. NALU, and its 135,000 members want to do this, just like you all do. Thank you.

Senator PRYOR. Bob, we thank you. We want to thank all of our panelists this morning.

For the benefit of our panelists, our audience, and ultimately the members of the Senate Committee on Aging, this fact: nearly two-thirds of the persons who enter nursing homes become impoverished in just over 3 months. This is a group of people that fall in the crack, as Sam has mentioned. Of course, he is not even talking about nursing home care at this point in his particular case. But we do know for a fact that many, many become impoverished in the first several months in a nursing home and in a hospital, and I don't know that it's going to get any better if we have the services out in the homes, Jim, and I know that you have certainly been a strong advocate of that.

Jim, I would like to ask you the first question and maybe you and Nelma Bennett can answer this together. To what degree are

supplemental Medi-Gap policies responsive to home health care needs? What recommendations do you have for the development of better community and home based care coverage? Would you try to summarize that as quickly as possible?

Mr. MEDLEY. Thank you, Senator. My experience with the Medi-Gap coverage is pretty limited because the vast majority of our folks, that we serve, I don't believe they fall into the area that Mr. Lane was referring to, because the average Arkansan is at or below the poverty level and I believe that paying for additional insurance is out of their reach. I think it's unrealistic to expect someone who is living on less than $400 a month to be able to afford monthly premiums. As far as the coverage, I don't receive much in the way of complaints on that. I think they cover the people pretty well if they can afford it. I think the problem is being able to afford any additional cost.

I recently had the experience of—a few years ago my father died and my mother is 73 years of age and she works part time to help supplement her income. She doesn't have any serious illnesses at this time but Social Security wasn't enough just to maintain her, in just paying for her food, electricity, and utilities, and she has been very conservative and very frugal. Her home is paid for and her car is paid for, but I can assure you that every dime has a place to go. To pay for additional health coverage for the average older Arkansan, I think, that's just unrealistic. So that would be my response to your question.

Senator PRYOR. Jim and Nelma, let me ask you this question. In dealing with the constituency in this part of the State, do you find that a large number of the population have no health coverage at all—say in a private insurance program or any kind of a health coverage program?

Mr. MEDLEY. I think Nelma and I both would probably like to answer that. From my perspective, I would say the vast majority do not have any additional health-type coverage, other than Medicare.

Ms. BENNETT. Yes; that's what I have found, Medicare and then Medicaid, but no other additional insurance.

Mr. MEDLEY. We're not talking about just over 50 percent, we're talking about probably 90 to 95 percent of the people we see are without health coverage.

Senator PRYOR. Now, I've heard of many instances where individuals—in fact, we've heard about some today, I think—should be accepted in a Medicare skilled facility but because of the difficulty in finding a Medicare certified facility, they are in their homes. Do you have any instances, or many instances, under which you are providing care to individuals who really should be in a skilled care home?

Mr. MEDLEY. Yes, Senator, there are many instances of this, and I can think of several folks that I have visited myself in their homes. The problem that you commonly hear, and I'm not sure we haven't heard it today, there's a common misconception that the nursing homes throughout the State are Medicare covered; they are not. You find very few. I've been told, and I believe it is correct, that there are only five in Arkansas that are Medicare—that will accept Medicare or are Medicare approved. I believe we only

have one in western Arkansas that I am aware of that is Medicare approved; the others are Medicaid and that means that you have to be in poverty before they are going to pay for your nursing home care.

Senator PRYOR. I always have a question mark here. To certify that you are eligible for Medicaid you must have sold everything other than retaining $2,500 in assets; is that correct?

Mr. MEDLEY. That's basically right. In fact, we see more very tragic things happening. We have, at times, seen elderly people, so the spouse won't be completely impoverished they will, at times, get divorces so that the spouse going to the nursing home will be considered in poverty. You know, that's not something that older people take lightly, but sometimes financial necessity causes that to happen.

Senator PRYOR. If you have any questions or any statement you'd like to make a part of our record today, I want you to feel very free to fill out the forms available on the table. In fact, if we keep our questions and answers fairly brief we may have an opportunity, in just a moment, for questions from the audience.

Mr. MCDONALD. I just wanted to make a statement in regard to the Medicare coverage for nursing homes. It is covered, as defined by Medicare, as a skilled nursing need. The definition for skilled nursing need is quite extreme. So I don't believe in either situation discussed today, the patient would qualify under the definition of skilled nursing need. Mrs. Lovett, you were talking about your situation of where you had trouble finding a reason for him to be covered in a hospital admission; I think the problem would persist in the nursing home, in terms of whether or not the nursing home would consider it a skilled nursing need under Medicare, or if it would become a custodial issue once again.

Senator PRYOR. As I understand Mrs. Lovett's case, and I may be wrong on this, because her husband's illness has been diagnosed as a custodial problem, with Alzheimer's disease, and not being eligible for Medicaid coverage, if your husband would break his hip then he could go to a skilled care nursing home—he would then be eligible. But he would have to break his hip, or break his arm, or fall down the steps or something of that nature, or be diagnosed with a more serious illness.

Mrs. LOVETT. If he had an acute illness with fever or enough white blood cells in his urine specimen—I'll ask the doctor there—would that not be the criteria where he could enter the hospital? He doesn't have that right now and meeting that criteria, with the vacancy in the only Medicare approved home in his district, is the big problem. He does have acute attacks once in a while because he has a chronic urinary problem. It wouldn't be because of Alzheimer's, it would be because of a urinary problem, but having that coincides with the vacancy in the nursing home is almost an impossibility.

Dr. PHILLIPS. Mrs. Lovett, you've told us what is a problem, currently not the scope of this discussion, but that is the PRO reviews and the very stringent requirements for admission to the hospital and the setting of standards that are really beyond the province of you or your doctor, in making such a decision; those decisions are not made by us. As a matter of fact, I'm really not sure where they

are made. I'm sure Senator Pryor doesn't know either because we've been trying for some time to find—if you ask the PRO people in Forth Smith they say they are made in Dallas, and if you ask the people in Dallas, they say they are made in Washington, and if you ask the people in Washington they say we have local control. I can't find anybody responsible for the ridiculous situation, like you've just described.

Mrs. LOVETT. Neither can my doctor.

Senator PRYOR. This is the type of thing we're seeking answers to.

Mrs. LOVETT. And if he meets the criteria to enter the hospital now, if he should be sick enough, would that pay for his nursing home? No one can give me any answers or my doctor any answers.

Mr. MCDONALD. There would be no guarantee that if he gets in the hospital for an acute-care reason that he would also meet the requirements for skilled nursing care in a nursing home.

Senator PRYOR. Dr. Phillips, I believe you made the distinction between care for the elderly and care for the general population, or younger population, but it concerns me that—I think this fact is correct—throughout this country only about 300 medical school faculty members are involved in teaching some aspect of geriatrics. I think Arkansas, by the way, has made some good strides in the area of geriatrics and gerontology in recent years. But as the population becomes older more rapidly, we're going to see a tremendous need to increase and accelerate those programs on gerontology and geriatrics. I wonder if you might have any comments that might relate to that, that might encourage the increased training in our medical schools and other institutions of higher learning.

Dr. PHILLIPS. One of the discouraging things about caring for geriatric patients has been discussed briefly here earlier. The constraints regarding hospitalization, reimbursed nursing home care, do not lend themselves to encouraging a physician to devote his time to caring for this age group because he feels embattled on one side, he can't make logical decisions based on the need of an individual. He must make those decisions based upon what the retrospective review of the case will lend him.

For example, anecdotal, but a patient was seen in the emergency room, having fallen. The x ray done in the emergency room indicated a small fracture of the hip, a line fracture. The patient was hospitalized overnight. As oftentimes happens, the x ray was read the next morning by the radiologist when it was dry and there was no fracture. The patient was sent home and the admission was totally denied as unnecessary. In other words, to people making such a decision from a PRO standpoint it was an unnecessary admission. How many of you would like to be sent home with the probability that you had a hip fracture, and we'll put you in tomorrow if you really do have one. It's an unrealistic approach to practicing medicine and until those constraints, Senator, are removed, I don't see any increase or any desire for our medical students to spend a lifetime in this area.

Senator PRYOR. Mr. Lane, I liked your comment about one of the solutions that you have to the problem that we're discussing today, and that's that everybody buy the insurance policy that pays for

everything. Now, is this generally your theory on how we solve this crisis before us?

Mr. LANE. My reference to a policy that pays for everything is simply a comprehensive medical insurance policy.

Senator PRYOR. From the private sector?

Mr. LANE. Yes.

Senator PRYOR. What incentive or what sort of leverage, you might say, what's the carrot and the stick for us in the Government to hold over peoples' heads to make them buy such a policy? Let's take Jim McDonald, for example. Jim's a nice looking young fellow, looks like he is about 28 or 30—I don't know how old he is—but now what is going to make Jim buy a big comprehensive policy there and spend several hundred dollars a month on it? What is that carrot and stick that the Government's got to use?

Mr. LANE. What's going to help Jim, if he can still qualify, is when he gets out of the hospital, is his first large hospital bill. That's the best incentive I know of. Try paying some doctor and hospital bills for a while and you'll be happy to pay the lower premium to prevent this completely destroying your economic base.

Senator PRYOR. Well, now, should these programs be in addition to Medicare, Medicaid, and Medi-Gap?

Mr. LANE. No; these, I think, should be primary. A comprehensive medical hospital plan now cannot and will not pay in addition to benefits paid by a government entity, or by the Medicare system. When you get to be age 65 your private insurance ceases; you are eligible for Medicare. You can buy Medicare supplements. Between Medicare and the Medicare supplement available, we feel that is catastrophic health insurance.

Senator PRYOR. Is there any policy written today that would apply to the case of Sam Hocutt's mother or Sarah Lovett's husband, that they've testified about? Would any policy take care of this type of treatment that they need at this particular time?

Mr. LANE. Very few insurance policies treat nursing home or custodial care at this time. They are available on the market. To answer your specific question, if these individuals were insured under a comprehensive major medical plan, I'd say, "Yes, they would be insured under it."

Senator PRYOR. In other words, Mrs. Lovett could get some home health care for her husband or she could put him into a nursing home that would be covered by——

Mr. LANE. No, sir. I sell policies every week that cover hospice care and home health care. They are available on the market through the public sector.

Dr. PHILLIPS. Senator, before you leave that subject, I'd like to make one comment. A few commercial companies are beginning to market long-term care policies and these include some custodial care benefits. There really hasn't been any rush enrollment for a variety of reasons, such as cost and complicated exclusions, and some rather less than attractive per diem benefits, and total benefit caps. Now, Prudential, it's my understanding, which is the AARP Medi-Gap sponsored carrier, has test marketed such a product and strangely enough the acceptance rate was very low. Now, whether that acceptance rate was lack of education on the part of the recipients, or whether it was the increased cost was so great

and was not spread among a large enough risk pool, I don't know why that test marketing failed. But I suggest that the solution to this is, one, a very large risk pool. In other words, you can't expect the elderly, over 65, to pay for long-term custodial care for everyone over 65. That is simply unrealistic. They don't have the funds. We are going to have to have long-term custodial care available and spread over the entire population so that you pay for it some way during your lifetime, or we will never be able to afford this.

Mrs. LOVETT. I'm with Prudential, AARP, and I pay $69 a month for this policy, but they won't help me unless Medicare helps me.

Senator PRYOR. If Medicare helps you then their policy triggers in?

Mrs. LOVETT. If Medicare helps me then they will pay for a year, which I think after I've taken care of him this long, and at this stage, I've saved the Government enough money that I deserve this year. I need it badly.

Dr. PHILLIPS. I didn't mean to confuse you, Mrs. Lovett. When I said that such a policy was available from Prudential, I said it was test marketed, but not in this area. A test market is when the policy was designed and then they went out to sell it to see what kind of demand there was for it. To my knowledge, such a policy is not available to just AARP members. The point I was making was that in test marketing such a policy, they were marketing it to only AARP members and I don't think that's a wide enough risk pool, because I think the premium would have to be too high for it to be a substantial policy.

Mr. MCDONALD. May I make a couple of comments? One is, I think, part of the problem that you're noting is that, yes, the supplemental policies are tied to Medicare. Consequently we come back to the same issue of how these issues are defined. What is skilled nursing care? What requires acute hospitalization? It's the definitions that we come back to again and again, that are used by Medicare, that put people in situations where they can't turn to the right or to the left.

Senator PRYOR. For example, in 1985, my figures show that only 220 hospices in America, out of 1,429, participated in Medicare. Is that right? It's a very, very, small number.

Mr. MCDONALD. It has been a slow start for the hospice program.

Senator PRYOR. And is that because of the Medicare definitions—definitional problem?

Mr. MCDONALD. I think that's a major cause of that. The requirements are so stringent—for example, the Medicare certified hospice program in Mountain Home had to look to a community 60 to 80 miles away to get a contract for an occupational therapist, in order to meet their requirement. When, in fact, utilization of occupational therapy in hospice is very minimal at most. It is not a service that is required very often. The other point I wanted to make, continuing with the example of myself. If I were diagnosed with cancer and I had to quit my job because I had a prognosis of less than 6 months, I would not be able to continue my insurance coverage, necessarily, through an employer long enough to treat the entire illness. Medicare would not take effect until after I had been disabled and dead for 18 months. To qualify for Social Security disability you have to be disabled for 6 months. To qualify for Medi-

care under Social Security disability you have to have been disabled for a period of 2 years. So there is a terrible gap there that does need to be addressed.

Senator PRYOR. Bob, go ahead, and then I'm going to allow anyone in the audience who may want to make a very brief statement, or ask a question to do so, and then we will let each panelist have 1 minute to conclude.

Mr. LANE. Three quick items. Any legitimate insurance company, if it's got an adequate premium and an application that is not a fraud, will stand by and pay its benefit just like it, as a contract, promises. It is a contract and it must stand up in court, perhaps, some day. Jim, if you contacted a fatal illness and you were group insured, if you applied within 31 days after the day your group insurance terminated, you would have the right to a conversion policy that would have no lapse in coverage. It would pick up that day after your group insurance terminated, so you would have coverage for your pre-existing condition.

One other thing, insurance is a hedge against a contingency that may never happen. If your house didn't burn down last year, did you cancel your fire insurance? Just because you didn't get sick last year did you drop your health insurance? If you want to insure long term, that is, after-65 custodial care, the time to start planning is not when you are 65, the time to start planning is when you are 25.

Senator Pryor, I think we're going to have to have some tax incentives, as y ur handout remarks state very clearly. I think this might be the key ultimately to long-term custodial care for everybody.

Senator PRYOR. Well, we're even talking about something called the IMA. We have the IRA, now we're talking about the IMA. That's an individual medical account, which would be a tax deduction, that you could pay into so much a month or a year or whatever. We're just beginning to look at that now and to look at this whole area of catastrophic coverage and the gaps and so forth that we've talked about this morning, the individual type problems we've discussed with our panelists.

Is there any statement from the audience this morning, a very brief statement, or maybe a question or two? Would you stand, please, and give your name for the record?

Ms. GARRETT. My name is Lou Garrett and I just want to clarify. I have a major medical insurance policy now and if I continue to pay into that or be covered with it until I am 65, do I not lose that policy then and have to go under the Medicare? Can I retain my private insurance, Blue Cross plan?

Mr. LANE. You don't lose it. It ceases to be a valid contract that you signed with the insurance company.

Senator PRYOR. Sounds like he has lost it, to me.

Mr. LANE. That's as far as it goes because the private insurance industry cannot duplicate benefits that the Federal Government provides through Medicare. Why would you want to keep it? It won't pay.

Ms. GARRETT. Because the Medicare benefit package does not provide adequate care for long-term care. In northwest Arkansas we have a lot of people that have moved in and retired there. And

when they get 65 they are not covered under Aetna, or Prudential, and they are used to, you know, very, very adequate health insurance coverage and then all of a sudden they are on Medicare. They would just as soon keep their private policy and they have no choices.

Mr. LANE. If the Federal Government would push their Medicare age back to age 70, the insurance company would push their coverage up to age 70, or whatever magic number we've got. The Federal Government is what is dictating the cessation of your personal coverage.

Senator PRYOR. Thank you. That was a very good question.

Ms. O'NEAL. I'm Winifred O'Neal and I would like to publicly call you a shining star in the Senate, because 23 years ago there was absolutely no help. The rest home wouldn't have my husband; he was too much trouble. I couldn't get anyone to come in and help because they were afraid of him. Now, this was 23 years ago. I just want to give you this accolade. I call you a shining star.

Senator PRYOR. You're very nice. Thank you.

Mr. GEBHART. My name is J.D. Gebhart. I'm retired from the military service. I'm also a retired disability civil service employee. We get involved in this—not to confuse you, but things are primary and secondary. The Government gave me CHAMPUS in 1960. They gave me CHAMPYA, which is another insurance. They also gave me an insurance deal of civil service, when I worked for there, and I retired from disability there.

The gentleman here said people do not look—which is true—into a program of making sure they are protected on down the road. Sometimes this is an economic problem too. My concern is this—and I'm sure that other people are confused. I have insurance with, we'll say, the civil service and I pay a premium of $100 and something a month. I'm a reserve officer; I pay that as a supplement. I also am a 100-percent, total, permanent, disabled veteran. I have certain outpatient/inpatient there. I'm also over 65. I hate to admit it. So I moved over from CHAMPUS to Medicare and I pay a premium there.

So when I go to the provider, which is a doctor, nurse, or somebody, they always question me, "Do you have insurance protection?" The answer is, I'm insurance poor. I've provided this to myself years ago, which I anticipated I might die down the road; no problem. So I maintain that sponsor should know so much that I don't have to ask them who is primary, who is secondary, who is third and who is fourth, to send my claim in and not disturb me. It doesn't disturb me but I talk to people out in the boonies and they'll say to me, "Colonel, how do you do this and how do you do that?" I know, but what I'm saying is you've got a confused community.

I'll say this, I've got a doctor's appointment this afternoon at 2 o'clock. I'll call and make sure they are ready because I'm not going to sit like an idiot, but that's OK. But they are going to send that thing to the Government. Now, the reason I say the Government, and I'd like to point this out, after a real detailed comparison between CHAMPUS and the civil service insurance sponsored by the Government, one of them you have to make out a piece of

paper that is so confusing I have to get my lawyer to help me; I'm talking about CHAMPUS or CHAMPYA.

The other one, which has been in business for years for the civil service, each year you can pick out an insurance company that you want. They call it open season. I never have any difficulty if I send in my claim, and I write them letters; Aetna. I could use Blue Cross-Blue Shield, it doesn't make any difference. But every year they expedite that claim. I'm not talking about disbursement, I'm talking about they expedite that claim to where it comes back to me within 6 or 7 or 10 days. You can get involved in CHAMPUS—and you say, we're not here for CHAMPUS—I'm talking about old age. When you get to a certain age.

You say, "What's poverty?" Poverty, no one can explain it, whether it's $2 or 98 cents. I listened to a TV program last night and I turned to my wife and said, "Are we in poverty?" She and I. She said, "Well, I really don't know." What I'm saying is, and I'm talking about the elderly now. There is a program in there between CHAMPUS, Medicare, and civil service. I look around here and I can identify several civil service employees and I'm sure they are sitting here now, worried, but the law changes so quickly, my civil service people after I retired for disability—had to retire—they were primary. Today the U.S. Government—I called them on the phone to get it from the horse's head—today, VA is primary on me up to a certain point and then they bill Medicare, and what's left over they send to the person to which I pay the highest premium. I say that that old person that I'm paying that high premium to, I should send it to Aetna, and let the Government, VA, and so on pick up the slack, but that ain't the way it goes.

Senator PRYOR. Thank you, Colonel.

Ms. NICHOLS. I'm in a very similar situation as Sarah Lovett here. My husband also got Alzheimer's, and he is 50. You think you have enough savings, but interest now has dropped very low so your interest and savings does not cover very much. We were taught that Social Security was not enough; one should save because you needed something besides your Social Security. I have two children still at home and I thought we were covered insurancewise, but he requires custodial care and I finally got a little help from the VA, but I understand there will be a means test and I probably will not qualify, and they do not want any part of it because he is not treatable. They are only interested in treatable things; they are not interested in custodial care.

Senator PRYOR. In other words, that case is another one that falls through the cracks, just like Sam and Sarah's.

Ms. NICHOLS. He is in a nursing home that when I go on private pay after 6 months—the VA finally put him there. It is costing $63.50 a day and I will have to transfer him to a cheaper home, and there goes your savings. In the past if you were able to save anything you paid a high income tax, you paid a high property tax. We were in business until he had to take disability. There's many of these people on Medicaid, they are old and they are not able to earn very much and now with inflation, what they did save does not reach. Some of the younger ones are beginning to wonder why should I save anything. I can't save enough to take care of me. They see what happens to your savings. So why not booze it up,

party it up, live high off the hog? Their attitudes are not good anymore.

Senator PRYOR. Thank you for those comments.

Ms. MUSGRAVES. The implication seems to be that once you are in a nursing home you are covered; your troubles are over. Medicare does not reimburse a facility that provides an adequate care nursing home. I'm a licensed practical nurse and I made some calls yesterday. This particular home had 70 patients and they had six nurses on the morning shift, taking care of 70 patients. They admitted that, at least, half of them are bedridden. This is 12 patients per nurse and it is a physical impossibility to give them adequate care. You have six bed baths. I would say three out of six would be incontinent; that means several baths. Some of them have to be hand fed. I could go on and on. There is no room for tender loving care. I mean, you can't get the physical part done if you are nursing 12 elderly patients.

Senator PRYOR. And you are an L.P.N.; is that correct?

Ms. MUSGRAVES. Yes.

Senator PRYOR. I appreciate that comment. This will be our last question, and then I'm going to give each panelist 1 minute to summarize.

Mr. SHARP. One of the questions that I wanted to hear discussed, hasn't been nothing said, and that's the high cost the medical profession demands from the patient. It is almost immoral to me what the doctors and hospitals charge. My wife recently came down with cancer, spent 38 days in the hospital; almost $27,000. I've been told America is the only nation on Earth that bases their health cost on ability to pay. I believe that's wrong.

Senator PRYOR. We've got one doctor here and I don't know if he wants to—you weren't talking about just doctors, you're talking about the whole area of health services?

Mr. SHARP. If the doctor can answer it, I'd appreciate it.

Dr. PHILLIPS. It's impossible to answer that in the short time we have. Let me make a brief stab at the cost of medical care and cost of hospitals. Hospitals have one source of money. Sparks Regional Medical Center gets all the money it gets from people who come into the hospital for care. It's a labor-intensive service. At one time they were the second largest employer in Sebastian County; that means that more people work for Sparks than any other business in the city, except one. If the hospitals are being run inefficiently and if we have too many nurses, then perhaps we could lower the cost some. Unfortunately, I just heard a nurse comment about shorthanded, and we've been laying off nurses at Sparks for the last 2 or 3 years, and all of you are probably aware of that. We've been cutting our staff because we can't afford them. Because the decrease in Medicare reimbursement cut down the funds that come in and the hospital has to pay its bills. This is a complex subject. I agree with you. Let me give you one example: my mother was in the hospital last summer for 11 days and her bill was $16,500.

Mr. SHARP. You could afford it though.

Dr. PHILLIPS. No, sir; I didn't afford it. The Government afforded it, plus her AARP policy. My mother had a Medi-Gap policy. She bought it through AARP, Prudential Insurance Co. The total cost of her cardiovascular surgery, including all of her bills and her hos-

pitalization, was in excess of $22,000. The total cost out-of-pocket to her was less than $400. She had what is called a Medi-Gap policy, a good one; she bought it and paid for it every month. Now, what I'm saying is that acute-care coverage, and that's not what we're talking about, but acute-care coverage is readily available today. Mr. Lane will sell you one, I'm sure he markets such a policy to supplement your Medicare coverage, and your care for the first 150 days of an illness will be covered. Most physicians, at least the physicians I'm associated with, accept assignment so your payments are covered there. Now, I can't tell you what to do about chronic care; I don't have an answer for that, Senator, and that's the problem.

Senator PRYOR. Do we have any other statements from the members on the panel?

Mr. HOCUTT. I'd like to follow up on that. Let me follow up to the doctor's comments there. My mother was insurance poor. She had total coverage, a comprehensive major medical coverage, she's a retired schoolteacher. My dad is a retired minister. Her hospitalization cost, both in the hospital and rehab hospital, came to approximately $120,000. Her out-of-pocket expenses were less than $1,000. The crack is, that's done now. Now what does she do? Because she has an irreversible illness or affliction she can't go back into the hospital and be treated. She needs care less intense than she found in the hospital but more intense than what you would find in a skilled nursing care facility.

If I were to summarize, at this time, I can say that we can take care of her at less cost to the system, as it's structured, at home, doing what we've been doing. But it is very trying physically and emotionally. If the system could be modified, as Jim has suggested, to allow for some in-house relief so that my sister can sleep late one morning, because this is a 7-day, around-the-clock, 24-hour—every 6 hours somebody is doing something. There is no light at the end of the tunnel. I suggested to her when I was there 3 weeks ago, "Hey, kiddo, we don't need another patient. We've got to work out a solution so that within another few months you know what you can do to catch your breath."

Modification of programs for patient care at home would close some of those cracks.

Mr. MEDLEY. Very briefly, I do believe that our country is faced with a very serious health care problem, with regard to both the acute care and chronic care. For example, today with the diagnostic related groupings system that Medicare applies to hospitals, very many people are discharged as quickly as possible in order for the hospitals, as referred to earlier, so that they cannot go broke in hospitals. Many in this country have gone broke. We can't just look at hospitals and say they are just trying to charge exorbitant prices; that's not entirely true.

In any case, when people leave the hospital with acute illnesses they are oftentimes still very sick. They may not be sick enough to remain in a hospital, and at times that is even questionable. But for the most part let's say that they are discharged with the best of

intentions, and they still need some care at home, and if they are widowed, which many of the elderly women of this country are, there is no one there to care for them and they look toward the secondary care of home help. Medicare, if you're 65 years of age or older, will care for you somewhat; if it's acute illness they will care for you. But not continuous care. Continuous care under Medicare does not mean 24-hour-a-day service, it does not mean 20, 15, 10, it doesn't mean even an hour every day; it means every other day at best. In fact, in most cases, if you serve someone with home health care more than 3 times in a week then it is going to be denied.

The next problem is finances. Let's suppose that this acute illness starts lingering on and develops into a chronic illness. Once it is determined by Medicare that this person is not going to get well, in other words, they are going to pay for this home health care for not more than 3 days a week for approximately 4 to 6 weeks, anything beyond that they determine as chronic illness. But if the person's income is above the $376 a month, which would make them Medicaid ineligible, if they are above that then they are out in the cold. They either pay for it themselves or they do without. They can, possibly, in some cases, go into a nursing home, become impoverished, and be cared for there if they qualify for nursing home placement. That, to me, is a very serious problem from both the acute side of it and the chronic side, and we see lots of cases like this. Several of my nurses are here today, like Nelma, and they deal with this on a daily basis.

Senator PRYOR. Nelma, do you have a final statement?

Ms. BENNETT. Yes. I, as a registered nurse, have had many rewarding experiences, but in trying to work with clients out in the field in their home, I've had frustrating times trying to meet the Medicare guidelines. I know how frustrating it is for me, and I can only imagine how it is for the families.

Senator PRYOR. Thank you, Nelma. Mrs. Lovett, would you have a final comment?

Mrs. LOVETT. I would just like to make another plug for the Homemaker Home Health, the thing the Government was trying. If you help the caretaker that would save this caretaker from breaking down and becoming another expense for the Government. I know it would save the Government that way. I had two 6-hour days, and one 3-hour day, which gave me time away and this really helped.

Senator PRYOR. Thank you.

Mr. HOCUTT. The only comment I would like to make in closing is that I'm a conservative. We have the best health care available, as far as I'm concerned, anywhere in the Nation. We should be proud of what our industry in the health care business has generated—and he's not paying me to say this.

My mom received the best care in the world; it was costly. She had planned to cover the cost of this with a comprehensive health insurance program. Where I see us having a gap now is expanding the program and reprioritizing long-term custodial care as she requires, because we are living longer. I turned 55 last week. I have a major medical coverage with my employer which will be affected in its terms after I retire, when I turn 65. I hope I have planned over the last 30-year working career to cover myself if I have this cata-

strophic affliction. My mom and dad did a good job of planning. But it seems to be discrimination to have to eliminate your assets down to a point before you can get any relief.

The closing comment I would offer would be we have a good health care industry and facilities. We need to massage it a little bit and reprioritize our thinking and close this gap for those elderly that are suffering from an irreversible affliction, because they are getting more and more. Thank you, Senator.

Senator PRYOR. Thank you, Sam. Dr. Phillips.

Dr. PHILLIPS. I would like to thank you and your staff for coming, and thank you and your staff for their interest in a very complex problem. I have no other comments.

Senator PRYOR. Thank you, Doctor.

Mr. MCDONALD. I have a couple of closing comments I would like to make. One is in reference to the statements earlier about nursing home staffing and the ability of nursing homes to provide adequate care for the patients. I think the comment from the floor was very appropriate and points out a need for more intervention in not only the home but also in the nursing home. This is why the hospice programs are interested in providing care and support for terminally ill patients that are residents of nursing homes. Patients are not receiving skilled nursing care there. Private-pay patients in nursing homes are considered residents and are eligible for Medicare; Medicaid patients are denied their right to hospice in nursing homes.

The second issue I want to talk about refers to the way the system denies services based on the ability to pay. If you are Medicare eligible you have to play by their rules, and supplemental policies do play by their rules, by their definitions under the law. An assessment by a nurse, a physical assessment, looking for potential problems and hoping to prevent serious complications is not considered skilled nursing care; giving an injection is. We're waiting until we need to intervene to cover the services that are needed. That is one of the primary issues that I see that faces us.

And back to the insurance coverage, I think there is a real bind in there. I'm not wishing to argue the point that there are good comprehensive insurance policies, but if I did become disabled—there may be a way to convert that—but I may not have the income to pay for it. We still have a very serious problem in providing care during the time when someone becomes disabled and the time they are eligible for services.

Senator PRYOR. Jim, thank you. Bob.

Mr. LANE. We've all acknowledged, and I certainly do, the fact that insurance premiums are high. I will say, though, that whenever the cost of being provided for in the health care industry levels out or decreases, your health insurance premiums in the private sector will also level out or decrease.

Let me read you just three short items here about cost. The Office of Management and Budget proposes to reduce Medicare physician's fees, which the Government identifies as "over priced." The Government says that it has discovered that for the last decade the Medicare economic index, used to make annual adjustments in doctor's fees, has overstated the doctor's cost of doing business. The index will be recomputed to correct this technical

flaw, according to budget documents. Also targeted for reduction are home health services under Medicare which the administration perceives as being overused. The draft budget approach is instituting a charge of about $5 for each visit to a beneficiary's home by a health worker. Medicare officials will develop a system to identify heavy users of the Home Health Care Program, such as beneficiaries receiving more than 100 visits in a calendar year, or "physicians who order daily visits for periods found to be excessive."

I'll end with this note. Above-average profits were reported by hospitals for the first year under Medicare's prospective payment reimbursement system. According to a report made by the inspector general of the Department of Health and Human Services, hospitals showed an average profit of 14.2 percent on their Medicare revenue in 1984, about triple the average profit on all patient revenue in preceding years; 892 hospitals located in 9 different States were surveyed for the report which provides significant data on how the Nation's hospitals are fairing under the new payment system. Now, you can see why your health insurance costs are pretty high. Thank you, Senator.

Senator PRYOR. Well, ladies and gentlemen, we've gotten a lot of food for thought at this meeting this morning—I should call it a hearing; that's what it is. Once again, this record is going to be made available to you, if you so request it by mail, and especially to the members of the Senate Committee on Aging, in Washington, DC.

I would like to thank you for coming and I would like for all of us to give a round of applause for our panel. We really do appreciate all of you very much.

This hearing now stands adjourned.

[Whereupon, at 11:30 a.m., the committee was adjourned, to reconvene at 2 p.m., Aug. 28, 1986, at the Pulaski Heights Presbyterian Church, Little Rock, AR.]

HEALTH CARE FOR OLDER AMERICANS: INSURING AGAINST CATASTROPHIC LOSS—Part 2

THURSDAY, AUGUST 28, 1986

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Little Rock, AR.

The committee met, pursuant to notice, at 2:04 p.m., at the Pulaski Heights Presbyterian Church Hearing Room, Little Rock, AR, Hon. David Pryor, presiding.

Present: Senator David Pryor and Senator Dale Bumpers.

Also present: Theresa M. Forster, legislative aide; Ann Pride, press secretary; and Frank Thomas, administrative aide.

OPENING STATEMENT OF SENATOR DAVID PRYOR, PRESIDING

Senator PRYOR. Ladies and gentlemen, I'm David Pryor, and I would like to welcome all of you to this open hearing of the U.S. Senate Special Committee on Aging. Over the last year or so the areas of long-term care and catastropic health care have received increasing attention. And I believe that the testimony we receive during these 2 days in Arkansas will be most helpful in formulating a policy for long-term care and catastrophic coverage which is responsive to the needs of elderly Americans.

Yesterday in Fort Smith we held part 1 of this hearing, and we examined in depth the problem of long-term nonacute health care delivery and other issues related to our topic. Today we will conclude our hearing with greater emphasis on insurance coverage problems and the examination of additional long-term catastrophic coverage considerations.

Clearly there are some very serious gaps in health care coverage for older Americans which leave the potential for financial ruin and emotional devastation.

Historically the working definition for catastrophic illness has been limited in scope, concentrated on illnesses which require intensive, expensive, and acute-type care. There is no question that this type of illness can cause severe financial hardships, but now we are beginning to see that any condition which requires continuous health care expenditures can and probably will be catastrophic.

In addition, it has become increasingly clear that as our population ages, the demand for long-term institutional and community-based care and acute-care services for serious illnesses will only increase. For example, today there are 1½ million Americans residing in nursing homes. By the year 2000—that's not long off—that number is going to rise to 2.2 million; by 2020, 2.9 million. By 2040,

4.5 million people will be residing in nursing homes in America. Currently 2.1 million of the noninstitutionalized elderly need the help of another person in carrying out one or more basic physical activities, and 2½ million elderly need the help of another person in carrying out home management activities. By the year 2020 that number may increase to more than 11 million. By 2040 it will reach 18 million Americans.

Future advances in health technology may lengthen the lives of many more of our eldest Americans, placing additional demands on an already inadequate health care system. We must make every effort now to solve these health care system access problems.

Over the last several years the administration has proposed that acute catastrophic problems be dealt with through an expansion of the Medicare Part A Program and that this expanded coverage be paid for by imposing an additional charge for all beneficiaries on each of the first 60 days of hospitalization. The Congress has resisted this proposal. It has resisted this proposal primarily because it increases substantially out-of-pocket expenses and cost to all beneficiaries who are hospitalized, while helping only the very small percentage of individuals who require prolonged hospitalization.

Before becoming the Secretary of Health and Human Services, Dr. Otis Bowen—and, incidentally, Dr. Bowen was Governor of the State of Indiana at the same period of time I had the privilege of being the Governor of the State of Arkansas—proposed an alternative approach for dealing with this type of catastrophic expense, imposing a small monthly premium to cover the cost of a catastrophic policy. Secretary Bowen's proposal brought this longstanding problem to the forefront of health care consideration, and precipitated widespread discussion on the catastrophic coverage issue. As part of his State of the Union Address, President Ronald Reagan directed Secretary Bowen to conduct a 1-year study of how Government and the private sector can provide catastrophic medical protection.

The Commission Secretary Bowen appointed has been meeting throughout the course of this year, and just last Tuesday the Commission held its final meeting and issued a draft report of recommendations for the Secretary to consider. Secretary Bowen will meet with the President next month to review this issue, will submit his recommendations to the President and then to the Congress by the end of the year.

The Commission's report has defined catastrophic illness primarily in terms of cost rather than in terms of the type, intensity, or duration of a specific illness. The report states, and I quote:

> The economic consequences of illness become catastrophic if the out-of-pocket expenses of the individual or family, excluding expenses reimbursed by insurance, employers, and government programs, become to that family financially devastating.

Several of the options from the report have been proposed in legislative form. And some are quite close, I might add, to being enacted into law. It is my hope that with this hearing this afternoon we will begin to gather a substantial base of information and reactions to the committee's draft report on which to begin our discussions on catastrophic coverage in Congress.

I look forward to the testimony we will hear today. Also let me mention that we do have a stenographer, a court reporter, and that this hearing transcript will be supplied not only to you, should you request it, but also to my fellow colleagues on the Senate Special Committee on Aging of the United States.

And, finally, let me also thank Reverend Dunn and the Pulaski Heights Presbyterian Church for their generosity in allowing us to meet in this fine facility this afternoon for this hearing.

Also, we will have, I hope, one additional treat about 1 hour from now, if Senator Bumpers' airplane arrives safely and if we can get him from the airport to here before we conclude, we will have a statement by our friend Senator Dale Bumpers. Let me again thank all of you for coming.

I'm getting ready to call the witnesses for the first panel to our hearing table. After we receive all of the witnesses' testimony and after questions have been asked by myself to these witnesses, then it will be the audience's turn, should we have that time to do so, to ask questions of myself or the members of our panel.

On panel 1, let me ask Mr. Eubanks, Mr. Sheffield, Dr. Mitchell, and Mr. Lantrip if they will come forward to the committee table. We have a very distinguished panel of witnesses this afternoon for our first panel. First we have Commissioner Eubanks of the Arkansas Insurance Department. Our Commissioner Eubanks will be accompanied by Mr. Ron Sheffield, who is the assistant commissioner for consumer affairs of that department. Both of these gentlemen have a considerable familiarity with the problems of catastrophic and long-term health care coverage, and we welcome their testimony.

Next we have to my left Dr. George Mitchell. Dr. Mitchell is president of Blue Cross-Blue Shield of Arkansas. Blue Cross-Blue Shield is the largest provider of Medi-Gap policies in our State, and I know that Dr. Mitchell's testimony will be very constructive.

Next we have Mr. Dewey Lantrip of the AARP. Dewey must be about the most knowledgeable individual in our State, in the area of health care for the elderly. He has been past chairman of the AARP State Legislative Committee. He has served 2 years as coordinator of the AARP Health Care Program. He is a member of the State medical board and has served on the State opticians' board and is a member of the Governor's Advisory Council on Aging. He is also a member of the Geriatrics Committee for the Baptist Medical Systems. Dewey recently completed a comparative study of Medi-Gap and long-term care insurance. We are honored to have Dewey with us today, and I'm wondering what he does with all his spare time.

Now we will have the opportunity to hear a brief, and I say brief, 5-minute statement from each of our witnesses today. And if I ring the bell on y'all at the end of 5 minutes, it is not because I don't like you, or am not interested in what you have to say, but any longer statements may be submitted for the hearing record, which will be mailed to our audience today.

Commissioner Eubanks, you are first. We look forward to your statement.

STATEMENT OF ROBERT M. EUBANKS III, LITTLE ROCK, AR, COMMISSIONER FOR THE ARKANSAS INSURANCE DEPARTMENT

Commissioner EUBANKS. Thank you, Senator. Thank you for the opportunity for Mr. Sheffield and myself to address one of the most critical issues of the 1980's. Although the Medicare Program has made significant strides, in the area of acute health care for the over-65 population, how to finance nonacute health care services has not been addressed properly until now.

In January 1985 the National Association of Insurance Commissioners Medicare Supplement and Limited Benefit Task Force was expanded to include long-term care. With this new charge, the National Association of Insurance Commissioners has explored the many facets of long-term care. Long-term care insurance can be described as a product for the catastrophic expenses, associated with a wide range of medical and support services, to provide to persons who have lost some or all capacity to function on their own, due to chronic illness or condition and who are expected to require such services over a prolonged period of time.

Other services range from direct medical care to rehabilitative services and services and assistance with the basic functions of daily living such as eating, bathing, and walking. Several factors make this the problem or task for the eighties. One, there is a dramatic growth, as you have noted, in the over-65 population. Two is that medical breakthroughs that, while advancing life expectancy, also increase the frequency of chronic conditions and hence functional impairments. There is a family structure that forces the elderly now to seek formal long-term care. In 1984, $13 billion was spent in out-of-pocket payments for long-term care. This was approximately 50 percent of the total. Only 1 percent of that total figure of that $25 million was in the form of private insurance. These costs obviously will continue to grow.

As a regulator, several problems in developing an adequate product have to be addressed. One is lack of consumer awareness. An AARP Study Commission in 1983 showed that one-third of those asked had no idea of the cost of long-term care. And 80 percent thought Medicare would finance those costs; 50 percent thought Medicare supplement policies would also meet those costs. Many people also deny that they are personally at risk, and few are willing to admit discretionary income, to those later risks, when they feel healthy and would rather use that income for a more enjoyable pursuit.

The fact that there has been very little demand for the product until now, has also prevented product development. Low demand equates to adverse selection in the insurance industry and hence very high premiums. How do we go forward? Education, of course, is what must be done as far as what is covered and not covered by Medicare, and Medicaid, as a Medicare supplement policy. Also the need to develop actuarial data for this new product. We also must determine the role of the State and Federal Government. When you mandate standards, they do cause problems. Wisconsin has a maximum elimination period of 60 days. They prohibit the requirement of a hospital stay, and they require that all levels of nursing

home care are covered. It is now so expensive a product that only one company will offer it.

West Virginia and Kentucky require all health insurers to offer long-term health policies. West Virginia also requires that bereavement counseling is mandated to family members. These types of burdens have placed the cost of these products beyond the reach of normal citizens, so we must continue to look at alternatives, an IRA-type of deduction for medical care. I believe H.R. 35 would allow nontaxable distributions to use for eligible medical expenses, tax credits at the State and Federal level for expenses incurred or premium payments.

At this time the National Association of Insurance Commissioners has developed a model act and regulation for long-term care products. I would ask Mr. Sheffield if he would cover those bases.

Senator PRYOR. Commissioner, thank you very much for your statement. Mr. Sheffield.

STATEMENT OF RON SHEFFIELD, ASSISTANT COMMISSIONER FOR CONSUMER AFFAIRS, ARKANSAS INSURANCE DEPARTMENT

Mr. SHEFFIELD. Thank you very much, Senator. At the present time Arkansas does not have a long-term care policy which has been adopted or accepted by any particular company. We do have a company which has filed a, quote, "long-term care contract and is presently being reviewed." One of the considerations given to a long-term care policy are those particular provisions which could prove to be onerous on any particular citizen buying the contract. That being elimination periods.

An elimination period is basically the number of days for which there are no benefits paid under the policy until the consumer has been so confined to the necessary nursing care facility or hospital facility or intermediate care facility or whatever facility is prescribed under the policy. An elimination period of 20 days or more would necessarily not allow the contract to be approved under the NAIC model code. An elimination period of any more days than that could make the policy such that it would not be worthwhile to the consumer. An elimination period of 180 to 360 days basically has the consumer paying a substantial amount of money out of their pocket for a policy they thought would help them should they have to be so confined.

Also an aggregate maximum limit is required under the model act. This aggregate maximum is the total amount of money over the lifetime of the policy that the policy would have to pay toward the prescribed types of health care under this long-term care contract.

One of the problems that I've seen in reviewing the information that's been sent to us is that the long-term care contract could possibly confuse consumers who have a nursing home policy thinking that a nursing home policy and a long-term care policy are substantially the same. If anyone has had an opportunity to review a nursing home contract or seen one, it prescribes what type of health care must be provided, what type of facility you must be confined in prior to the company making any payment. Under the model act, as Commissioner Eubanks has stated, a company cannot

require that you be hospitalized prior to the long-term care contract coming in and paying benefits to you.

Also along the lines of a Medicare supplement contract, the Department has recognized and continues to recognize confusion in the sale of Medicare supplement policies that are marketed today. I'm sure that many of you who have watched TV or who may be over the age of 55 or 60 have in some way been contacted, offering to sell you a, quote, "Medicare supplement contract." If you've seen some of the ads on TV that we view all the time, a consumer can be confused as to what benefits are payable under the policy and those which are not. Terminology such as, "We pay everything that Medicare doesn't" can be and is, as we receive nothing but complaints in my particular division, is a misleading term that unfortunately consumers of our State don't always fully understand. Terminology such as, "We pay 100 percent of everything that Medicare doesn't" can and often is a misleading term which normally a person looking at it would assume that every bill that they get that a doctor sends to them the policy is going to pay 100 percent of that. Unfortunately that terminology is misleading and confusing for our senior citizens.

As I stated earlier, every time our phone rings, it's a complaint. No one call us and says, "I hope you are having a good day," OK? So when we get those types of inquiries, we require ourselves to review them and make certain that the policies that senior citizens buy—and I say senior citizens in quotes because some insurance calls you adult Americans or some other nice name for you, to get you to purchase a product without providing to you the necessary information that you need to make a knowledgable and a worthwhile purchase. Steps the department is attempting to take and we are proposing to do this in the future hopefully, is to see that our senior citizens buy a product that has some economic value to them and is not purchased based on the sales pitch but is based on their need. Unfortunately in America today you need a Medicare supplement contract to supplement your Medicare, simply because the nature of the medical bills you receive, simply because of the cost of the health care.

We at the Arkansas Insurance Department feel that we must move forward to help you in seeing that the policies sold do help you and are not purchased because some silver-haired individual on TV tells you that this is the best thing since hot popcorn. In acute care and long-term care we must be allowed a certain amount of flexibility in regulating these particular products because they are new products, products that are yet untested, products which probably because of the nature of what they will do for you will be expensive; and, again, since I sit in the seat that gets the complaints, worry about, because it would be so easy for someone who has less than your best interest at heart to convince you that this particular product is again the best thing since hot popcorn. And unfortunately consumers do not read the important part of the sales pitch, and that is the contract that's delivered to them.

Long-term care contracts are going to be necessary in the future. There's no two ways about it, because as Senator Pryor has said and Commissioner Eubanks has said, the average age of America is getting older and older. My particular job—and I think it's a very

selfish job, because I hope some day to live long enough to be called a senior citizen. If we can regulate the industry to such a point that the products sold have economic value that are worthwhile, then when I reach that hopeful age of retirement, I won't have to worry about products that are sold that have little or no economic value.

I would like to thank Senator Pryor for asking me to make a presentation today.

Senator PRYOR. Thank you, Ron, very much, for that statement. We hope you reach that golden age, also. Our next witness is Dr. George Mitchell, president of Blue Cross and Blue Shield. Thank you, Dr. Mitchell, for coming. If you would hold that microphone fairly close or nearby, I think the audience might hear better. Before Dr. Mitchell gives his statement, if I might interrupt, George, many of you write my office or call about problems relative to Medicare, Medicaid, and this, that, and health care concerns, and the person that you sometimes talk to by phone or correspond with by mail is Theresa Forster. She is on my staff in Washington, and she is spending this time in Arkansas helping us conduct these hearings. I wanted you to be able to put the face together with the name. We're glad Theresa is here with us. George.

STATEMENT OF GEORGE K. MITCHELL, M.D., LITTLE ROCK, AR, PRESIDENT, BLUE CROSS AND BLUE SHIELD FOR THE STATE OF ARKANSAS

Dr. MITCHELL. Thank you, Senator. I would first like to commend you for conducting these hearings, because catastrophic health insurance and long-term care is indeed a critical issue for this country, and we appreciate your longstanding interest in these and other matters, particularly as they relate to the elderly and the disadvantaged.

I would like to share with you the position of Blue Cross and Blue Shield on catastrophic health care insurance and long-term care, not only as the administrator of Medicare in Arkansas, but also as the representative of a major private health insurer which also includes Medicare supplemental policies.

The issue as we see it is how to assure all Americans and their families that they are protected against financial catastrophe as a result of the onset of acute or chronic illness. And we would define, as Senator Pryor has previously alluded to and the Advisory Committee to Secretary Bowen, that we must define catastrophic illness in terms of the economic consequences of the illness to the individual or the family rather than in terms of the type or the intensity or duration of a specific illness.

In terms of the scope of the problem for acute care of those over 65, the major gap is lack of Medicare supplemental coverage and Medicaid by about 20 percent of the beneficiaries, primarily those of low income. For acute care of those under 65, the primary gap is that about 17 percent are totally uninsured of the entire population of the country. And for long-term care, virtually all the population in this country is uninsured, except those who are impoverished that are covered by Medicaid.

We believe that there are three basic principles that bear consideration in discussing this topic. In terms of the role of Government in general, we feel it should be one of facilitating private sector solutions. This should be accomplished through incentives rather than mandates. Incentives offer flexibility and the potential for innovative action instead of the rigid prescription of mandated solutions. The Government should not attempt to dictate the design of health benefit plans, but rather should monitor the marketplace, and above all assure consumer protection, as has been alluded to by Commissioner Eubanks.

Second, catastrophic coverage should be viewed as an enhancement rather than a replacement for adequate basic health insurance protection.

Third, in the design of viable solutions, coverage of catastrophic illness is not susceptible to a simple solution. A combination of actions will be needed, all of which taken together offer a reasonable solution.

Flexibility and diversity should be encouraged. Solutions should be targeted principally to those not presently protected.

In our position statement on this entire matter of catastrophic coverage and long-term care, we basically address it to three different populations. That's in terms of acute care for people over the age of 65, acute catastrophic care for people under the age of 65, and then long-term health care costs for all people. In view of the need to move along in terms of time, I will only address coverage for acute catastrophic expense in the over age 65 and long-term care.

The primary objective for coverage of acute catastrophic expenses in people over age 65 is to provide protection for those low income beneficiaries who now lack a protection through a combination of public and private sector efforts.

A secondary objective is to expand the scope of catastrophic protection available in the private market. Options for consideration would include enhanced beneficiaries' education about Medicare coverage, enhance beneficiaries' education about Medi-Gap, including the comparative information on coverages, premiums, and loss ratios, expand Medicaid eligibility, subsidized Medi-Gap for those who can't afford existing policies, and provide Federal tax credit for low income beneficiaries so that they may purchase Medi-Gap.

In terms of long-term health care cost, this is the most serious and perplexing problem we have, because the vast majority of Americans are not protected from catastrophic cost of long-term care. The private long-term care insurance market has not yet developed. This market has not developed due to a combination of lack of consumer awareness of risks and a lack of employer interest in adding group benefits, a number of actuarial uncertainties and the availability of so-called free Medicaid coverage.

Our objective for long-term care coverage is to develop a coordinated public and private sector policy to encourage a variety of approaches, such as long-term care insurance, medical IRA's, continuing care communities, appropriate Medicaid protection, and public education. Options for consideration would include promote tax favored IRA's or other savings arrangements to finance the purchase of long-term care insurance, educate the public about the need to

have long-term care protection, improve the data on cost and utilization of long-term care services. Finally, practical research into ways of distinguishing levels of long-term care need.

In closing, we feel that private insurance products that act to provide catastrophic protection should be widely and consistently available to all segments of the population at reasonable premium rates, considering the underwriting risks involved and relevant regulatory requirements. Thank you, Senator Pryor.

Senator PRYOR. Thank you, Dr. Mitchell. Mr. Dewey Lantrip. Dewey, thank you for coming. We look forward to your statement. At the conclusion of your statement, I will ask the panel just a few questions, and then we will move on to our next panel.

STATEMENT OF DEWEY LANTRIP, LITTLE ROCK, AR, VOLUNTEER, AARP STATE LEGISLATIVE COMMITTEE, AARP STATE HEALTH CARE COORDINATOR, AND MEMBER OF THE GOVERNOR'S ADVISORY COUNCIL ON AGING

Mr. LANTRIP. Thank you, Senator Pryor. Thank you, Theresa, for inviting me. The short notice of this hearing made it impossible for me as a volunteer consumer to poll any of the groups that Senator Pryor mentioned that I work with, so that means in reality that the statement I'm going to give you is primarily my own thinking. And after hearing the other speakers, I don't see how it could be much more different than what they've said.

The plan I will discuss is somewhat similar to the one advocated by Representative Claude Pepper of Florida, in that a part C would be added to Medicare. It would be handled by Medicare similar to the way parts A and B are handled. It might be contracted out to eligible organizations such as doctors' groups, hospitals, nursing homes, HMO's, PPO's, insurance companies, and so forth.

Now, the part C plan. This plan would be somewhat similar to part B in that it would be optional, and the patient would pay a part of the cost. This is what part C would pay for. You have to be rather nervy to do what I'm doing—spell out a plan in detail—but I'm doing that only to present the concept.

Part C would pay all the deductibles of part A and part B so there would be no need for supplemental insurance. The patient would not have to bother with that. The coinsurance—the 20 percent—would also be paid for by part C.

The cost of prescription drugs above $300 a year would be paid for by part C. The cost of prescription eyeglasses would be paid with probably a minimum deductible that the patient would pay. The cost of nursing home care, part C would pay for all of that above $300 a month. The cost of community-based or home-based health care above $100 a month would be paid by part C.

Now, just so that you follow me a little better, I'm going to read what the patient would pay. The patient would pay $50 a month for part C. That is all it would cost the patient. You know, it would be up or down from that, depending on the inflation situation, and what the national finances are. This could be deducted from the patient's Social Security payments. The patient would pay nothing for part A and B supplemental insurance since this would not be needed. He would pay nothing for covered services for parts A and

B when providers, doctors, hospitals, and so forth, accept assignment. The amounts providers charge above the Medicare allowable charge, when providers do not accept assignment, the patient would have to pay for that.

The patient would not have to pay more than $300 a year for prescription drugs. That's only $25 a month. He would not pay more than $300 per month while in a nursing home and not more than $100 per month while receiving community- or home-based health care. That gives a push for community- or home-based care in that it is cheaper to the patient.

Some of the advantages of this plan appear to be as follows: It is realistic on costs since the patient shares in the cost of the new services to be added. It eliminates the Supplemental Insurance Program which in some cases has been, as already brought out, very confusing to many older people. It eliminates the need for commercial nursing home insurance, none of which so far that I have seen appears to be designed to serve the needs of persons who need only custodial nursing care. There is no policy like that that I've seen. Part C plan will serve the large group of low to medium income Americans who are above the Medicaid income level, who under the present plan and policy, find it very difficult to give up almost all of their resources before they can enter a nursing home on Medicaid. Plan C is such that additional services, such as providing hearing and dental care, could be added when financial resources are available.

There are many details that I have not included since my goal is to present only a general idea of the kind of plan that I think might work. Thank you, Senator.

[The prepared statement of Mr. Lantrip follows:]

CATASTROPHIC HEALTH INSURANCE
by Dewey Lantrip, Little Rock - A Volunteer

I have served a total of seven years as a volunteer on the AARP State Legislative Committee and as the AARP State Health Care Coordinator. I am a member of the Governor's Advisory Council on Aging and the Over-60 Consumer Representative on the State Medical Board. I have served on a number of committees in working with the State and Area Agencies on Aging and the State Health Department. This statement does not necessarily represent the thinking of any of the above groups. The short notice of the hearing made it impossible to survey or poll any of the groups. Therefore, the following statement is primarily my own thinking.

The plan I will discuss is somewhat similar to the one advocated by Representative Claud Pepper of Florida, in that a part "C" would be added to Medicare. It would be handled by Medicare similar to the way Parts A and B are handled. It might be contracted out to eligible organizations such as doctors' groups, hospitals, HMOs, PPos and insurance companies.

PART C PLAN

This plan would be somewhat similar to Part B in that it would be optional and the patient would pay a part of the cost.

PART C WOULD PAY

. All deductibles for Part A and for Part B.
. The co-insurance (20%) for Part B.
. The cost of prescription drugs above $300 per year.
. The cost of prescription eyeglasses.
. The cost of nursing home care above $300 per month.
. The cost of community based and home based health care above $100 per month.

THE PATIENT WOULD PAY

. Nothing for Part A and B supplemental insurance since none would be needed.
. Nothing for covered services for Part A and Part B when providers (doctors, hospitals, etc.) accept assignment.
. The amount providers charge above the Medicare allowable charge when providers do not accept assignment.
. $50 per month for patient's cost of Part "C". (This could be deducted from the patient's Social Security payment.)
. Not more than $300 per year for precription drugs.
. $300 per month while in a nursing home.
. $100 per month while receiving community or home based health care.

Some of the advantages of this plan appear to be as follows:

1. It is realistic on costs since the patient shares in the cost of the new services to be added.

2. It eliminates the supplemental insurance program which in some cases has been confusing to many older persons.

3. It eliminates the need for commerical nursing home insurance, none of which so far appears to be designed to serve the needs of persons who need only custodial nursing home care.

4. It will serve the large group of low income persons just above the Medicaid income level who under present policies find it very difficult to give up almost all of their resources to enter a nursing home on Medicaid.

5. The plan is such that additional services such as providing hearing and dental care could be added when financial resources are available.

There are many details that I have not included since my goal is to present a general idea of the kind of plan that I think might work.

A PARTIAL LIST OF SEVERAL 1986 MEDICARE SUPPLEMENTS
Showing The Cost Per Month And
Most Or All Of The Main Items In The Supplements

NAME & COMPANY	ACCEPT AGES	COST PER MONTH	MEDICAL DEDUCTIBLE PART B PAID BY YOU (YR.)	MEDICAL BILLS PER YR. YOU AND MEDI-CARE PAY BEFORE SUPPL. PAYS ANY	HOSPITAL PART A DEDUCTIBLE PAID BY YOU EACH BENEFIT PERIOD	WAITING PERIODS ON AILMENTS MEDICAL ADVICE GIVEN PAST 6 MOS.	PAYS SOME ON THESE PRIVATE NURSE IN HOSPITAL	SKILLED NURSING CARE	AMBU-LANCE	PRESC. DRUGS	MISC.
SECURE CARE BASIC Nat. Home Life	65+	$17.95	$200*	$700	$492	6 Mos.	No	Opt. For $4.95 Mo.	Yes	No	
AARP SUP. PLUS Prudential M-2	65+	$17.95	$200*	$700	0	3 Mos.	Yes	Yes	Yes	No	$5.00 Dues For Membership (Yr.)
SECURE CARE 65 Nat. Home Life	65+	$37.90	$200*	$700	0	6 Mos.	No	Opt. For $4.95 Mo.	Yes	No	
SR. CITIZEN SUP. Union Fidelity	65+	$47.29	$200*	$700	0	6 Mos.	No	Yes	Yes	No	
MATURITY MED. 65 Colonial Penn	65	$28.70	$200*	$700	0	6 Mos.	No	No	Yes	No	
	66-74	$32.15	$200*	$700	0	6 Mos.	No	No	Yes	No	
	75-79	$38.55	$200*	$700	0	6 Mos.	No	No	Yes	No	
	80+	$44.80	$200*	$700	0	6 Mos.	No	No	Yes	No	
SECURITY 65	65-69	$28.95	$200*	$700	0	6 Mos.	No	Opt. For	Yes	No	
Continental	70-74	$31.95	$200*	$700	0	6 Mos.	No	$3.00 Mo.	Yes	No	
American Life	75-79	$36.95	$200*	$700	0	6 Mos.	No	" "	Yes	No	
Insurance Co.	80+	$43.95	$200*	$700	0	6 Mos.	No	" "	Yes	No	
MEDICARE SUPPL.	65-69	$42.24	$75	$75	0	6 Mos.	No	Yes	Yes	No	Pays for first
Great American	70-74	$45.57	$75	$75	0	6 Mos.	No	Yes	Yes	No	3 pts. of blood
Reserve	75-79	$48.91	$75	$75	0	6 Mos.	No	Yes	Yes	No	
AARP SUP. PLUS Prudential M-6	65+	$21.95	$75	$75	0	3 Mos.	Yes	Yes	Yes	No	$5.00 dues for membership (yr)
MEDI-PAK Blue Cross-Blue Shield	65-74	$22.00	$75	$75	$246	90 Days	No	Yes	Yes	No	No forms to file
AARP EXTENDED SUP Prudential M-3	65+	$38.25	$75	$75	0	3 Mos.	Yes	Yes	Yes	Yes**	$5.00 dues membership (yr)
MEDI-PAK PLUS Blue Cross Blue Shield	65-74	$34.45	0	0	0	90 Days	No	Yes	Yes	No	No forms to file

*While you are meeting your $200 deductible on medical bills for the year, Medicare is paying $500 on them. This means that $700 worth of bills are paid by you and Medicare before these supplements pay anything. This $700 could be considerably higher if the physician does not accept assignment.
**This supplement pays 50% of prescription drugs after a $50 deductible, up to $500 per year.

This list is for your information only. No recommendation is given or intended for any particular supplement. For additional information, call the companies shown below. The above information was taken from brochures obtained from the different companies.

Blue Cross Blue Shield 378-2010
P. O. Box 2181 Little Rock 72203

Colonial Penn 1-800-523-4060
Cont. Am. Life 1-800-441-7004

Great American Reserve 1-800-824-2726
Nat. Home Life 1-800-523-7900

Prudential 1-800-523-5800
Union Fidelity 1-800-523-5758

Senator PRYOR. Dewey, thank you very much. Let me give all of you a fact this afternoon. Fact: A recent study by the House Committee on Aging on the elderly in Massachusetts found that 63 percent of elderly persons age 66 or over living alone deplete their personal financial assets totally after only 13 weeks in a nursing home. And for married couples age 66 and over, 37 percent deplete their savings within 13 weeks if one spouse required nursing home care.

I imagine that the same would apply generally here in our State. We see the devastation of assets being depleted if this occurs. My question first of the panel—and I hope that questions will be answered with some degree of gravity—what percentage of elderly individuals in our State do not have Medi-Gap coverage? I wonder if any of the members of the panel might answer that. George, maybe you could address that.

Dr. MITCHELL. Senator Pryor, in general, this is a national figure, and I suspect it's fairly true here. Sixty-six percent of Medicare beneficiaries have some form of supplemental insurance, and I would suspect that in Arkansas it would run about 60 percent, with another 15 percent having Medicaid benefits.

Senator PRYOR. About what would such a policy cost, an average cost of the policy be?

Dr. MITCHELL. Now, are you talking about the existing supplemental policies that do not cover long periods of care?

Senator PRYOR. Let's talk about first——

Dr. MITCHELL. What we have now?

Senator PRYOR. What you have now.

Dr. MITCHELL. They will run anywhere from $20 to $30 a month, maybe a little bit more. That's just a general range.

Mr. LANTRIP. I can give you a little more on that.

Senator PRYOR. Dewey, go ahead.

Mr. LANTRIP. But I don't want to interfere with him.

Senator PRYOR. Go ahead and interfere with him. That's OK. Go right ahead.

Mr. LANTRIP. We just recently made a chart on the ones that were advertised on television and the ones on which I got notices and letters. I answer all of these to get a copy of their brochure. Then I made a chart on these. They range from as low as $9.95 per month to about $80 a month.

Many of you know that Blue Cross-Blue Shield has Medi-Pak Plus, which is $34.45. You also know about AARP Prudential. Many of you have a $17.95, and there is a new one that is $21.95. They range all the way up. But the Blue Cross-Blue Shield one is the best guide to go by if you are looking at what you are asking about. The Medi-Pak Plus pays everything—all the deductibles and all the coinsurance, and that is $34.45 per month. That gives you a basic idea of a figure for the Medi-Gap cost.

Senator PRYOR. Dewey, thank you.

AUDIENCE MEMBER. That's under age 74, though.

Senator PRYOR. Under age 74.

Mr. LANTRIP. I should have mentioned that.

Senator PRYOR. I think we have some of these pamphlets out here if you did not pick up one. Theresa said there are just a few. It's done by the AARP: Medicare and Health Insurance. It's a very,

very good little pamphlet, I think, on explaining some of these very complicated things.

Second—I want to address this to Mr. Sheffield or Mr. Eubanks. Are there any efforts—let's take our State of Arkansas, and even nationwide—to police or to ascertain and to ultimately educate the public, especially the elderly public, on some of these policies that are advertised on television and newspaper and radio, as to which of those policies are good and which are not so good? Do you enter into that sort of advice for the general public?

Mr. SHEFFIELD. One of the functions of the consumer services division is to make certain when we talk to a consumer that they understand basically the policy they are buying, what the benefits are and what they will do. We are proposing in the upcoming legislative session new statutes that will basically make it a criminal offense for a Medicare supplement agency to unfairly represent a policy that he's selling to a senior citizen in the State of Arkansas.

The solicitation of material that is on TV is a very general type of solicitation material, and we have written the companies for it, and the regulation that we now have in place that regulates solicitation of disability or health insurance is somewhat antiquated, and we're going to look at that to determine what regulatory effect we will have over an organization—and, I guess, Senator, unfortunately it's going to be a little more lengthy response. Somebody someplace else other than Arkansas starts an association, and let's say he wants to call it the Good Time American Association. They start this association, and one of the benefits of the association is primarily, unfortunately, to sell insurance on a group basis. They have no other function. That's the only reason they are there is to say we are an association, and now we can circumvent certain laws and sell policies basically to our members. So when you get the solicitation material in the mail, you believe that you are joining an organization that's going to preserve Medicare or do something else, and that's the only reason they were ever formed. But, unfortunately, down in the bottom in the corner in the dark someplace is an application for some sort of insurance and they sell it to you as a member of the group. Unfortunately, consumers are not that well educated about insurance. They buy it, put it in a safe place, and they never read it, believing they are going to pay "100 percent of everything."

One of the things we must do is educate the consumers, not only in Arkansas, but in the entire United States. We are dealing with an area—and unfortunately those areas who want to do you harm know it—we are dealing with consumers who are older. When you sit down and talk to them and try to explain to them what the policy will do, they become confused. Also the person that comes in your house and sells it to you convinces you that he's looking out for your best interest. So when somebody is on the end of the phone and, if it's at the Arkansas Insurance Department, or the office on aging, or at the AARP that talks to you about your policy, you become even more confused. Then you begin to wonder if you've made a mistake or not. And some of our older Americans, older Arkansans, don't want to admit they have been hornswoggled, so they keep it to themselves and pay out—Dewey, I've looked at some of the policies that are sold here, and I'll tell you there are

more than a few that will cost you more than $80 a month. I've seen policies that will run close to $1,500 to $1,600 a year for a Medicare supplement policy that purports to pay, quote, "100 percent of everything," yet it does not.

So what we are attempting to do is get educated. I won't make an excuse for the department, but we are very limited in resources and personnel. We are attempting to get a toll-free hotline, 1-800 number, if you will, that individuals can call and we can assist them. There is a program that has been very successful in the State of Washington called SHIBA, which basically individuals from around the State would come into the central office in Washington. The insurance department there teaches, basically, an insurance course to volunteers who go back to their counties and assist people who have insurance problems. And that way they understand that the department is very limited in its resources and can't reach out and touch all 2 million and 400 and some odd thousand people in Arkansas, so there's a lot of things we could do, we hope to do, and right now under the constraints we have, it's difficult.

But I can say this, Senator, and I can say it without biting my tongue, if someone calls our office and asks for help concerning any type of insurance, we cannot promise you the outcome will be what you want. We can promise you that we will look into it as detailed as possible and hopefully give you an answer that you can hang your hat on.

Senator PRYOR. Three years ago Congressman Claude Pepper and I introduced and ultimately passed legislation to combat postal fraud in the form of misleading literature that is sent through the mail primarily directed to the unsuspecting elderly population. However, many of the insurance matters that we are talking about here today may not be specifically covered by that legislation, because it only deals with items sent through the mail of the U.S. Postal Service. Therefore you still see a lot of television and radio commercials and newspaper advertisements about these particular policies.

I want to thank our panel. I appreciate the contributions you have made this afternoon. I don't know what our panel's time situation is, but if we could impose upon them not to leave until we finish with the next few witnesses, there may be some questions from the audience for them. If any of you have to go, we certainly understand. We appreciate the opportunity we've had to listen to you this afternoon. I thank all of you very much.

Dr. MITCHELL. I just wanted to say that I have a copy of my statement, and I will leave them up here if anybody wants one.

Senator PRYOR. Now, ladies and gentlemen, I call Dr. Beth Smith, Dr. David Lipschitz, and Mr. David Clark to our witness table. Our panel now has expanded. We have—this is our second panel and our third panel this afternoon. We have first Dr. Beth Smith. Dr. Smith is the Associate Director of the Health Services Research and Development Field Program of the VA Medical Center here in Little Rock. They've been very active in developing the clinical program targeted to the aging population. Dr. David Lipschitz, Director of Geriatric Research, also at the Veterans' Administration. He has been active in development of a center for the

treatment of Alzheimer's disease and related disorders at the Veterans' Administration. With him we have Mr. David Clark of Mineral Springs who will discuss some of the problems he and his wife have experienced since she was diagnosed as having Alzheimer's disease.

On panel three, we're proud to have Herb Sanderson. He is director for the Office of Aging and Adult Services with the State Department of Human Services for the State of Arkansas. He was formerly director of the area agency in Jonesboro. Also Dr. Roger Busfield, the director of the Arkansas Hospital Association. And Dixie Dugan, the executive director of the Central Arkansas Area Agency on Aging in North Little Rock. Dixie recently completed a study for the Federal Counsel on Aging in Washington, DC, regarding the use of individual retirement-type accounts for medical expenses. This should be very, very interesting. We welcome her testimony as well as the testimony of all individuals today. Let the record show that Dr. Smith's testimony today reflects her views and her views only as an individual involved in aging programs and does not necessarily reflect the official views of the Veterans' Administration in Washington, DC. And we are proud to have Dr. Smith as our first witness. And, once gain, I would like to caution our witnesses to try to keep your comments to 5 minutes or less.

STATEMENT OF BETH SMITH, PH.D., ASSOCIATE DIRECTOR OF THE HEALTH SERVICES RESEARCH AND DEVELOPMENT FIELD PROGRAM OF THE VA MEDICAL CENTER, LITTLE ROCK, AR

Dr. SMITH. Thank you, Senator. The elderly and disabled of this country are being subjected to or stand in fear of catastrophic health care costs not presently covered adequately by private or governmental health insurance and benefits. The elderly and disabled are thus vulnerable to the loss of all of their assets which have taken a lifetime to accumulate. Government has provided health care to the eldery and disabled through the Medicare program. Yet this program currently is basically for short-term acute care health care costs. There is no coverage beyond a 150-day hospital stay (except for limited lifetime reserve days) and care in a skilled nursing home is limited to 100 days post-hospital stay. Home health is provided to supplement such care in certain cases. Private insurance, Medi-Gap policies, which some private insurers have reported as not profitable are still much too expensive and generally cover no more than what Medicare presently insures. Thus often only the Medicare deductibles and copayments are reimbursed. These reimbursed expenses are generally about the same as the policies costs ($500 to $800 a year). So current Medi-Gap policies are no solution to this problem.

Most elderly and disabled in need of a long duration of either expensive acute or long-term care often have to spend down their financial reserves until they are stamped poor enough to qualify for Medicaid. Why should we threaten the dignity and the economic security of our most vulnerable population in this manner? Surely a better solution can be found to resolve this horror and fear of so many of our elderly and disabled.

The appropriated role of Government continues to be to facilitate this kind of protection of individuals when the individual and the private sector cannot. We support the Bowen Commission's suggestion that cost neutral (to the Government) catastrophic care can be provided to the elderly and disabled at a very low cost to individuals through the following two mechanisms.

First, an actuarially sound premium could be added to part B of the Medicare Supplemental Medical Insurance Program whose premium is already being paid by the individual. The Bowen Commission estimated that for an additional annual premium of $165.50 in 1986 (or approximately $13 a month added to the current part B premium) unlimited inpatient and outpatient catastrophic care could be provided.

Current research has documented that increased economic levels are being achieved by our elderly. They would generally be able to purchase this better coverage, especially at the reduced rates achieved by placing the entire 28 million Medicare population at risk. This population appears willing to assume that burden. Indeed, as Dr. Mitchell suggested earlier, 65 to 70 percent of the Medicare beneficiaries are already purchasing commercial Medi-Gap policies with limited coverage at a much higher annual cost. The administrative costs of operating the Medicare Program are 2.5 percent, while overhead on an average Medi-Gap policy is much higher, as much as 50 percent. So implementation of the new benefits within the existing Medicare Program would be very cost efficient.

The change discussed above would not address the need for chronic long-term care. Thus a second proposal of the Bowen Commission is admirable. This is a proposal for the establishment of a voluntary Individual Medical Account, which is called an IMA, much like the Individual Retirement Account, the IRA's, that are so popular with the public. The IMA funds could be paid by the beneficiary into the Federal Insurance Contributions Act, or FICA, to pay only for catastrophic long-term care expenses during the person's high income years, say between the ages of 40 and 60. The amount of money that would have to be invested each year would be marginal, yet would generate high returns with compound interest and high yield securities and money market investments. It would receive a sheltered high marginal tax rate, and it would be used only for catastrophic chronic care. Should funds not be used, the amount of the funds invested plus some portion of the investment income could be returned to the beneficiary's estate. Thus the IMA would protect and possibly enhance, rather than deplete, a person's estate, regardless of his ultimate health outcome.

While the majority of the elderly and disabled could afford this coverage, what about those who cannot? First, reduced demand for Medicaid coverage would permit States to reduce their costs and perhaps expand both services and eligibility to groups currently "falling between the cracks" or to those persons currently just over the income level necessary to qualify for Medicaid but who are still too poor to obtain needed health care services or insurance coverage.

Second, perhaps other public programs such as the Veterans' Administration Medical Care System could provide care to more such

persons if catastrophic, very expensive care were more available in the community. The VA Medical Care System already is acting as a safety net for many poor veterans. The public and private sector is a maze of fragmented programs and services, often with lack of continuity and comprehensiveness with different eligibility criteria. Access to care by the individual is difficult. We see very resourceful people trying to pool their options to obtain needed care.

The John L. McClellan Memorial Veterans hospital in Little Rock, AR, served approximately 46,395 unique patients in the fiscal year 1983. Of these VA hospital users, almost one in five, 18.3 percent, were also users of Medicare and Medicaid. These VA Medicare and Medicaid users have both substantial VA as well as substantial Medicare and Medicaid utilization. For these VA/Medicare/Medicaid users, the average annual VA hospital stay ranged from 24 to 33 days, depending upon whether they were eligible for VA and Medicare, VA and Medicaid, or all three systems of care. Their nursing home or extended care stays ranged from annual averages of 146 to 181 days. They averaged from three to five outpatient visits a year, in addition to the VA paying an average ranging from $104 to $210 annually for community fee-basis care. All of this VA care provided is in addition to their average Medicaid claims per user of $2,123; an average Medicare A claims per user of $2,964; average Medicare B claims per user of $820; with a total average Medicare/Medicaid claim of $2,481 per year. This illustrates some of the need for care in our community and suggests there may be a need for monitoring the continuity of care so that resources are nonduplicative and cost-effective.

We should also heed a warning from other State and Federal experiences in many Medicare and Medicaid long-term care demonstration projects as well as our experience with the VA hospital-based home care and the VA medical model adult day health care alternatives. Even though some long-term care services are seemingly inexpensive (such as home and community alternatives to hospital and nursing home care) in the aggregate and over long duration they, too, can be catastrophic health care expenses. They often do not avert an immediate nursing home placement but over time these services appear to be able to keep people at home, where they prefer to be, even when sick. However, these services are not often true substitutes and nursing home care.

Most home care patients are different from the nursing home patients at least to the degree that even if they need nursing home care on all dependency measures, not all will use the nursing home. If society can then agree that it is very important to expand the system to provide this care to the dependent and their care providers in the home or community, then ethically we should find some basis other than the cost-effectiveness rational for providing these services. Certainly a continuum of care for the elderly as well as the dependent persons in the community under age 65 is needed.

Senator PRYOR. Thank you, Dr. Smith. Doctor David Lipschitz, M.D., Ph.D., Director of Geriatric Research, John L. McClellan Veterans' Administration.

STATEMENT OF DAVID LIPSCHITZ, M.D., Ph.D., DIRECTOR OF GERIATRIC RESEARCH AND DEVELOPMENT FIELD PROGRAM OF THE VA MEDICAL CENTER, LITTLE ROCK, AR

Dr. LIPSCHITZ. Thank you, Senator, I appreciate the opportunity to testify before this distinguished group. I would like to preface my remarks by saying that while we are focusing primarily on how we are going to pay for these particular programs, I would like to emphasize the tremendous importance of the quality of programs that we provide for the care of elderly Americans, and that's what I would like to specifically address today. I would like to focus my remarks on the current issues of long-term care for elderly individuals with chronic disease. A revolution is occurring in our health care system precipitated by the escalated cost of health care delivery. At the current time, disease related group reimbursement procedures is resulting in a commendable increase in hospital efficiency, the reduction in hospital stays, and an appropriate approach to placing a cap on the cost of providing health care.

The push to early discharge, however, is creating serious problems for elderly individuals. These patients are frequently dependent upon others for the normal function of living. They are placed in extreme jeopardy when discharged inappropriately from the hospital. This is likely to result in an increase in nursing home placement, the likelihood of frequent readmissions and a possibility of a great deal of suffering and even early death in the individual. This problem is occurring with ever-increasing frequency, in my opinion, and it highlights the need for developing appropriate health care systems to meet this challenge.

Programs for providing for the recuperation and rehabilitation of elderly individuals in the community is not readily available. On the other hand, the Veterans' Administration is taking the leadership role in this regard and provides an opportunity, an example of how the issue of long-term care can best be addressed. Programs show that with appropriate rehabilitation elderly individuals can become functional. Nursing home placement can be prevented and long-term health care costs can be reduced.

This approach can be achieved by a comprehensive interdisciplinary partnership between physicians, nurses, social workers, pharmacists, psychologists, rehabilitation experts, and others who complementarily assist and manage the patient.

Support services to provide for the care of home-based elderly individuals are essential and have been developed by the VA to a quite sophisticated level. The level of this kind of approach in the community makes it essential that attention be paid to the need for redirection of our health care priorities. A greater emphasis on intermediate care medicine is essential. In this environment, we can manage elderly individuals who are too well for the resources available in a sophisticated acute care hospital but too ill to return to their home. These facilities must be staffed by health care professionals who are expert in long-term care and geriatrics. For this reason it is important that our medical schools continue to focus on issues of the elderly and to train health care professionals in all disciplines in the practice of long-term care.

I would like to finally make some remarks with regard to the recently developed Center for Alzheimer's Disease and Related Disorders at our University of Arkansas for Medical Sciences. As you will hear from Mr. Clark, to my left, the lack of attention to this specific disease creates a great deal of suffering for the victim and his or her family. For the first time there is a comprehensive interdisciplinary approach to the evaluation, diagnosis, and management of Alzheimer's victims. Not only can appropriate diagnosis be made but strong support for the victim and their family is possible.

I must mention that in employing this particular approach we have found substantial numbers of victims who have potentially arrestable or even correctable disorders. Once the diagnosis is made, our attention focuses heavily on providing support for the family on education and in the very near future on developing opportunity for respite care and adult day health care. There are, however, some serious stumbling blocks to the potential success of this very important development. At the current time the primary care physician and the group who support him are reimbursed now by Medicare a total of $19.50 for the professional fee component of this service that takes approximately 5 to 7 hours. Reimbursement for neuropsychologic testing, psychiatric evaluation, and other support services, is marginal at best. On the other hand, Medicare and Blue Cross-Blue Shield does pay for the sophisticated magnetic resonance imaging and other high-technology procedures we request comprehensively to assist these subjects. This example highlights what I consider to be one of the most serious issues of long-term care. If health care professionals cannot make an honest living in long-term care, services will just not become available. It is pivotable that primary care providers are reasonably reimbursed for their services. Additional support services such as home care must also receive attention. It seems unlikely in the very near future that the budget for health care is likely to increase. If the challenge is to provide for health and welfare of Americans in their twilight years, there is a desperate need for a redirection of priorities as well as for innovative and creative programs to optimize older Americans' health and well-being. Thank you.

Senator PRYOR. Thank you very much, Dr. Lipschitz. Next, ladies and gentlemen, we have Mr. David Clark. David Clark has a personal story that he would like to tell us.

STATEMENT OF DAVID CLARK, MINERAL SPRINGS, AR

Mr. CLARK. I will need to be a little personal in order to hopefuly bring out some points a little later. My wife taught school 32 years. The last several years, high school English, and retired at the end of the 1976–77 school year. She was very active in church, school, and community activities, was chosen Outstanding Person for the years 1949 and 1959. She suffered a heart attack, September 1977. Excuse me. She recovered very well, and her health seemed to be good. Then one day in the spring of 1978 she called me at my work very upset and asked me to talk to our doctor. And, she said, "I can't remember. I'm afraid I'm losing my mind." Then crying, she said, "I don't want to go crazy. See if he can help us."

Looking back now, I can see symptoms of memory loss or depression. She would get upset over school work, especially deadlines and so forth. She even offended a few people by speaking rudely to them, very unusual for her. She would try so hard even then to do everything well. Since that phone call in 1978, we have been searching for some or any relief. And since that day, the disease has progressed rather slow, but sad and definite. We are referred to specialty physicians actually hoping to find the condition of depression, each time to be told, "I'm afraid it's Alzheimer's." All doctors and health personnel that we have seen have been very frank, open in their explanation and advise to us concerning Alzheimer's disease. However, it is frustrating to be told that there is no known effective treatment and the illness is even difficult to diagnose. This brings to my mind the greatest need for adequate research for early diagnosis and effective treatment of this horrible disease.

I would like to read a paragragh from a daughter of a well-known person now:

> There is presently no known cause or cure for this cruel disease. And the constant care needed by Alzheimer's disease victims is not covered by health insurance, Medicaid, or Medicare. It can bankrupt even the most affluent families.

Back to my own words, today financing my wife's treatment has not been a hardship for us. I might say, though, that her care has been home care, and I've provided most of that, and we have Medicare and Medi-Pak. And there were out-of-pocket expenses involved that we know is not covered by either. However, I would like to mention some medical regulations that seem unfair to me, and they are in regards to Medicare.

I would like to refer to an explanation of Medicare benefits. Here's one that happened in 1984 in October. This was a psychiatrist we went to, attempting to establish depression, really is what we were hoping for. He charged two visits, his charge was $200. Medicare approved $120 of this, then they applied this 62½ percent factor and reduced it to $75, and then they paid 80 percent of the $75, and they paid $60. Then another claim we have is for $8, and I don't mind paying the $8. It's for vitamin B–12. She had an extremely low count of vitamin B–12, and I understand this contributes to depression or some organic disorder maybe. Anyway, Medicare does not pay for drugs that are not approved as effective by the Food and Drug Administration; therefore, they approved nothing on that claim. I have another claim that's quite lengthy, and it totals $652.50 for the charges. Medicare paid $59.35. There again, in some of this process, they applied this factor of the 62½ percent psychiatric care. And these do not seem fair to me. I'll try to bring that out just a little bit further.

Now, as far as this graph here, if I may, this pink, 49 percent, supposing that's in relation to Alzheimer's and you apply 52 percent there, that would be the percentage of senile demential people in this area or we are trying to establish a total demential picture. And this is from the Berkley Rehabilitation Center in New York, and they say that 52 percent of these people have Alzheimer's disease, and it also puts 1 percent psychiatric disorder. So I'm asking

really is it a true psychiatric problem, or is it an organic disease that maybe should have the same coverage as any other disease.

I see other information in publications, and the physicians here would probably know what I'm talking about. They talk about the fiber tangles and so on, and I don't know anything about them. But that's what they call it. Then they mention the cortex of the brain and the pathway and so on. And it makes me wonder that maybe there could be some research that would get deep enough into this disorder to come up with a diagnostic procedure and a treatment process that would be helpful.

I had a few things I would like to mention, and that would be a home care program, sufficient care for the patient in order to keep them in their own home. They seem to do better than just sitting alone, with the help of a support group. I also read about a nursing home that treated only Alzheimer's patients, and it seemed to work out very well. And then if we could ask Medicare to look into the regulations in relation to Alzheimer's disease.

I'm going to briefly mention the tax reform, Mr. Senator, is coming up in Congress, I believe. And the way it's handled, you can have a considerable expense, a catastrophic-type expense for illness, and still involve your Social Security payment in your tax. It would be complicated to have some information on it, but I won't go any further on that. Then one other thing, the DRG program, I believe if a person is admitted to a hospital for Alzheimer's disease, I imagine they would call it an organic disorder and today it would be 7.6 days. There would be a spread of days under certain conditions of 25 and another spread to 35. Thanks a lot, Senator Pryor.

Senator PRYOR. Thank you, Mr. Clark. Yesterday in Fort Smith a woman testified before our committee. In her testimony she testified that she had been a schoolteacher in North Arkansas. Her husband was diagnosed with Alzheimer's disease. Home health care services provided only a portion of the needed care for that particular disease. Not eligible for needed care under Medicare, not wanting to spend down to their last $2,500 in assets so that they would be labeled as poor so they could get Medicaid, this lady decided to stop her school teaching career. She stopped in order to devote 100 percent of her time and attention to her husband. She could not get him admitted to a nursing home under Medicare. She could not get, one, him qualified for any particular program. This was a classic example of this family falling through the gap. Mr. Clark's situation with his wife is another situation of falling through the gap, falling through the crack, if you wish. And so I appreciate Mr. Clark coming with that personal statement today.

And now we're going to have Mr. Herb Sanderson. Herb, we're proud to have you here. Once again, I would like to urge, if I could, our statements to be as short as possible.

STATEMENT OF HERB SANDERSON, LITTLE ROCK, AR, DIRECTOR, OFFICE OF AGING AND ADULT SERVICES, ARKANSAS STATE DEPARTMENT OF HUMAN SERVICES

Mr. SANDERSON. Thank you, Senator, thank you for the opportunity to express my views. I would like to focus my comments on chronic illness in relation to catastrophic care, specifically related

to community-based care. For the written record, I've attached a copy of an article that addresses the subject in more detail. As you just said and Mr. Clark said, a disease like Alzheimer's is catastrophic in itself. But even in relatively mild forms, arthritis and diabetes can lead to catastrophe, not because of the disease, but because of the lack of a service system to provide simple interventions. Take, for instance, someone requiring an insulin injection. If an individual can give themselves a shot, he can remain at home. If a spouse is available to give the shot, he can remain at home. If he can afford a private nurse, he can remain at home. However, if he has palsy, poor vision, or for any other reason the above options are not available, he than faces a much bleaker future. The only option available to him may be to enter a nursing home. Is this an isolated case? Unfortunately not. An analysis of Arkansas Medicaid nursing home population in September 1983 revealed that 7.6 percent of the residents did not require nursing home care. Their institutionalization was avoidable, preventable. But because there were no other levels of care available, they were forced to turn to nursing home care at a substantial expense to themselves and the taxpayer.

I would like to make it clear that I firmly believe nursing homes are needed and they are a useful form of care. However, it is a tragedy to place someone in an institution that does not need to be there. We cannot afford it financially or in human costs. President Johnson said upon the signing of the Medicare legislation that, "now every American citizen will be able to insure himself against the tragedies of old age." That promise has not been fulfilled. Why? As Robert Butler has pointed out and some of the panelists pointed out, Medicare was set up as if to take care of a 40-year-old. It does not cover medication, foot care, dentures, nursing home care, respite care, day care, support services, homemaker, or case management services. More people now die of chronic than acute illnesses. Our health care delivery system has not responded to this change. Because lower less costly levels of care are not available, a relatively manageable chronic condition becomes a catastrophe.

In Arkansas we have taken some modest steps to meet the needs of citizens with chronic impairments. Those results are impressive. Between 1980 and 1990, Arkansas' 85 years of age and over population is projected to increase by 33½ percent. According to national statistics, 16 percent of this population group is institutionalized. Therefore, one could expect a significant increase in the State nursing home population between 1980 and 1990. To date this has not occurred. In fact, Medicaid statistics show there are virtually the same number of people in nursing homes today as there were in 1981.

Why is this happening? In my opinion, there are four basic reasons. First, the number of skilled home health agencies increased dramatically in the late 1970's and early 1980's. For the first time in the history of Arkansas, this made home care available for citizens on a large scale basis throughout the State. Second, personal care was added as an option under the State's Medicaid plan. This program is particularly important, because it is one of the few programs that provide care to people with a chronic disease. It will provide care over the duration of their life if needed. Also because

it is an entitlement program that has not been reduced or capped, all eligible citizens have access to it.

Also a program called the Client Assessment Team was begun to better control access to nursing homes. Before this project was begun, no one in Arkansas had ever been denied admission to a nursing home for medical reasons. This program has helped to see people receive the proper level of care they need. A State-funded case management system helps people negotiate the services that are available in the current system. For example, a client may need food stamps, weatherization, home delivered meals, skilled care to remain in their own home. Without a plan available to assist one in obtaining these services, it is unlikely they would be successful in receiving them, especially if the individual was homebound, illiterate, or lived in a rural area.

Other States such as Texas and Oregon have actually been successful in reducing the number of people in nursing homes by instituting community-based long-term care options. It is ironic to me that on one hand the Federal Government has mandated that elderly people be discharged from the hospital more quickly, while on the other hand it is cutting back on the few programs available to assist them in doing so, the Older Americans Act and the Social Services Block Grant. What this country needs is a long-term care system that provides an array of services to meet the needs of a particular individual. We have the capacity to do this. Until we have such a system in place, we will continue to pay too much for the wrong care. Thank you.

[The prepared statement of Mr. Sanderson follows:]

TESTIMONY BEFORE THE

SENATE SPECIAL COMMITTEE ON AGING

Health Care for Older Americans:
Insuring Against Catastrophic Loss

August 28, 1986
Little Rock, Arkansas

by:

Herb A. Sanderson
Arkansas Department of Human Services
Deputy Director for the
Division of Aging and Adult Services

Good afternoon. Thank you for the opportunity to express my views on this subject.

I would like to focus my comments on chronic illness in relation to catastrophic health care. For the written record I would like to submit a copy of an article which adresses the subject in more detail.

Robert Morris stated the following in 1981:

> "Chronic or long-term illness has generally been the stepchild of mainstream medical care, which has continued to concentrate its resources on short-term, episodic medical care, leaving the more complex long-term health-maintenace issues to other systems. As is often the case, the stepchild has not grown up and gone away. Instead, the unresolved dilemmas of long-term care now plague and distort all of health and medical care; acute beds are used for chronic care; timely discharge from hospitals is often difficult; nursing-home care is both costly and difficult to secure for the poorest (Medicaid-eligible) and the most ill patients; and care at home has grown less rapidly than high-technology medicine. Costs of health care escalate rapidly, increased in part by these distortions."

Many chronic diseases like Alzheimer's are catastrophic in themselves. But even relatively mild forms of arthritis and diabetes can lead to catastrophe not because of the disease but because of the lack of a service system to provide simple interventions.

Take for instance someone requiring an insulin injection. If the individual can give himself the shot, he can remain at home. If a spouse is available to give the shot, he can remain at home. If he can afford a private nurse, he can remain at home. However, if he has a palsy, poor vision, or if for any other reason the above options are not viable, then he faces a much bleaker future. The only option available to him is to enter a nursing home.

One of the most vivid statements I've seen concerning such dilemmas comes from a letter to the editor of the Los Angeles Times. It reads as follows:

> I'm an 84 year old woman, and the only crime I have committed is that I have an illness that is called chronic. I have severe arthritis and about five years ago I broke my hip. My son died 35 years ago; my husband, 25 years ago, so I wound up at a convalescent hospital. There are a few caring people who work here, but there are so many of us who are needy for that kind of honest attention. In the five years I have been here, I have had no choice - no choice of when I want to eat or what I want to eat. How can I begin to tell you that growing old in America is for me an unbelievable, lonely nightmare?

Are these isolated cases? Unfortunately not.

An analysis of Arkansas' Medicaid Nursing Home population in September 1983 revealed that 7.6% of the residents did not require nursing home care. Their institutionalization was avoidable, preventable. But, because there were no lower levels of care available, they were forced to turn to nursing home care -- at a substantial expense to themselves and the taxpayer.

I would like to make it clear that I firmly believe nursing homes are needed and that they are a useful form of care. However, it is a tragedy to place someone in an institution that does not need to be there. We cannot afford it, financially or in human costs.

President Johnson said upon the signing of the Medicare legislation that "now every American citizen will be able to ensure himself against the ravages of old age." That promise has not been fulfilled. Why? As Robert Butler has pointed out, Medicare was set up as if to serve 40 year olds. It does not cover medication, foot care, hearing aids, dentures, nursing home care, respite care, day care, chore services, home maker services, or case management.

More people now die of chronic than acute illnesses. Our health care delivery system has not responded to this change. Because lower, less costly levels of care are not available, a relatively manageable chronic condition becomes a catastrophe.

In Arkansas we have taken modest steps to meet the needs of citizens with chronic impairments. The results are impressive.

Between 1980 and 1990 Arkansas' population 85 years of age and over is projected to increase by 33.5%. According to national statistics, 16% of the 85+ population is institutionalized. Therefore, one could expect a significant increase in the state's nursing home population between 1980 and 1990. To date, that has not occured. In fact, Medicaid statistics show there are virtually the same number of people in nursing homes today (15,338) as there were in 1981 (15,028).

Why is this happening? In my opinion there are four basic reasons:

1) The number of skilled home health agencies increased dramatically in the late 70's and early 80's. For the first time in the history of Arkansas this made home care available to citizens on a large scale throughout the state.

2) Personal Care was added as an option under the state's Medicaid plan. This program is particularly important because it provides care to people with chronic disease -- over the duration of their life if needed. Because it is an entitlement program, funding has not been reduced or capped - all eligible citizens have access to it.

3) A pilot program called the Client Assessment Team (CAT) was begun to better control access to nursing homes. Before this project was begun, no one in Arkansas had ever been denied admission to a nursing home for medical reasons. This program has helped assure people receive the proper level of care they need.

4) A state funded case management system helps people negotiate their way through the maze of services that are available in the current fragmented system. For example, a client may need food stamps, weatherization, home delivered meals, and skilled care to remain at home. Without a case manager available to assist one in obtaining these services, it is likely one would not be successful in receiving them. Especially if the individual is homebound, illiterate, or lives in a rural area.

Other states such as Texas and Oregon have been successful in actually reducing the number of nursing homes patients by instituting community based long term care options.

It is ironic to me that on the one hand the federal government is mandating that elderly people be discharged from hospitals more quickly while on the other hand it is cutting back on the few programs available to assist them in doing so - the Older Americans Act and the Social Service Block Grant.

What this country needs is a well-funded long term care system that provides an array of services to meet the needs of a particular individual.

Until we have such a system in place, we will continue to pay too much for the wrong kind of care.

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Long-Term Care and the Aging Network

Herb Sanderson

Clearly, we live in an aging society. The statistics are becoming redundant for those who work in the Aging Network. Each day 5,200 Americans celebrate their 65th birthday; 11.7% of the U.S. population, every 9th American, is 65+; a child born in 1982 could expect to live 27 years longer than a child born in 1900; by the year 2030 over 20% of the U.S. population will be 65+. This graying of America is not something we think will happen; it is something we know will happen. While the statistics may vary slightly, the future is before us.

Are we prepared for this phenomenon? Unfortunately, I think not. Especially in the context of our health care "system," and in particular our long-term care "system." We know people are living longer and that the "old old" is the fastest growing segment of the population. We also know that the probability of becoming impaired or disabled increases substantially after age 85.

But as a society do we know how and if we want to care for our elderly? Do we know who should pay for the care? Do we know how much we are willing to pay?

Robert Morris made a powerful statement in 1979. As I read it today, the only difference I can observe between then and now is that six years have ticked off the clock:

> Long-term disability trends, if unattended, constitute a ticking-time-bomb threat to the health system as now

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> constituted and to responsible public-expenditure policy formation. This results because the volume of severe disability will increase due to basic demographic trends and improvements in human-survival techniques. This in turn will increase the net volume of demand for both institutional and at-home care services. These demands will distort the operation of our current health system by inflating costs through lack of preventive measures and through inflated expenditures for inappropriately used high-technology facilities such as hospitals and inadequately used primary manpower such as nurse practitioners, home-health aides, and natural support resources. Above all, current lack of attention to the needs of less disabled older citizens, whose numbers are rapidly increasing, will produce an alienation that can lead either to arbitrary reductions in support for health care or alternatively to exponential increases in expenditures for cost inefficient activities.
>
> It is possible that neglect now will lead us into a serious consideration of euthanasia as a national policy toward the older disabled since it is not clear that, as a society, we are ready to pay the price for the kind of life that our technology extends (Morris, 1981).

Health care costs continue to consume a growing percentage of the gross national product (GNP). In 1950 health care costs accounted for 4.1% of the GNP; in 1960 5%. By 1970 the figure had grown to 7% and by 1982 10% (Schimper and Clark 1985).

Table I details how older Americans used health care services in 1981, the last year spending estimates were available (U.S. Senate, 1983). The table shows that 85% of personal health care expenditures went for hospital, nursing home and physician services.

The magnitude of spending for institutional care tends to dwarf resources devoted to community-based alternatives. This fact was highlighted in the preface to *Allocating Health Resources for the Aged and Disabled:*

> Chronic or long-term illness has generally been the stepchild of mainstream medical care, which has continued to concentrate its resources on short-term health maintenance issues to other systems. As is often the case,

TABLE I

Personal Health Care Expenditures for Persons Age 65 and Over

	$ (Billions)	Percent
Hospital Care	$ 36.6	44.0
Physicians' Services	15.6	18.8
Dentists' Services	2.4	2.9
Other Professional Services	2.0	2.4
Drugs & Medical Sundries	5.1	6.2
Eyeglasses and Appliances	1.0	1.2
Nursing Home Care	19.4	23.3
Other Health Services	1.0	1.2
	$ 83.2	100.0%

Source: Health Care Financing Administration

> the stepchild has not grown up and gone away. Instead, the unresolved dilemmas of long-term care now plague and distort all of health and medical care; acute beds are used for chronic care; timely discharge from hospitals is often difficult; nursing-home care is both costly and difficult to secure for the poorest and most ill patients; and care at home has grown less rapidly than high-technology medicine. Costs of health care escalate rapidly, increased in part by these distortions (Morris, 1981).

The author underscores a critical point. This decade witnessed an extraordinary change rather quietly—for the first time in our country's history the leading cause of death was no longer acute illnesses, but rather chronic illnesses. The period from 1800 to 1980 was the era of epidemic death prevention. The major focus was on infection. The diseases included smallpox, the plague, cholera, typhoid fever, influenza, polio, tuberculosis, venereal disease and others. It is noteworthy that the World Health Organization has announced that smallpox has been eradicated from the entire world (Tarlov, 1983).

The increasing number of elderly is not necessarily testimony to an increasing life span, but to the fact more people are reaching old age. But, as Anne Somers writes so succinctly, "Paradoxically, the more successful we are in conquering acute disease and postponing death, the more we aggravate the problem of long-term disability" (Somers, 1982).

A new era is beginning. Dr. Alvin Tarlov spoke of a new objective for medicine when he addressed the 202nd Annual Meeting of the Massachusetts Medical Society:

> The central objective of medicine in the coming era will be the maintenance or improvement of individual patient functioning in the patient's normal environment while he or she performs usual activities . . . The outcomes of medical services of greatest interest to the patient and to society relate to the patient's ability to function at a high level in personal activities of bathing, dressing, and eating; mobility; physical activity; and optimal functions in the role of homemaker, spouse, parent, employer, supervisor, community participation, or citizen. To optimize these outcomes of care will be medicine's central objective for the period ahead (Tarlov, 1983).

In the past, and to a considerable degree at the present time, the answer to long-term care for the elderly has been the nursing home. We must question this policy both on cost and value system bases. The federal government spends more to maintain older persons in nursing homes than it does on the combined cost of home care under Medicaid and Medicare, all social services (Older Americans Act, Title XX, etc), SSI cash payments to two million older people, and all federally funded special housing programs for older people (Benedict, 1981). Yet less than 5% of older people are institutionalized.

A recent survey of nursing home residents in Arkansas revealed that at a minimum 7.6% of the beds were filled by people who had no medical reason to be there. But medical need may play only a small role in determining the need for nursing home care. Gender seems to be associated with the use of nursing home services. Over 70 percent of nursing home residents are female. The use rate for elderly women is nearly double that for elderly men. Marital status is another key factor in nursing home utilization. Nationally, about half the elderly are married. In contrast, only about 12 percent of elderly institutionalized residents are married. Childless women at any age have higher rates of institutionalization than their counterparts who have children; those with the largest families have about half the rate of institutionalization of childless women of the same age (HCFA, 1981).

During 1983 a state-funded Client Assessment Team in

Arkansas (a nursing home pre-screening project) found that of cases reviewed, 1,503 elderly had a medical need to be placed in a nursing home. However, 697 of the individuals chose lower, less costly, levels of care. It is also interesting to note that of those entering a nursing home, almost all, at least 95 percent, had incomes under $9,999. (Arkansas Office on Aging, 1984). There is much debate about the cost-effectiveness of in-home and other community-based care. While it is beyond the scope of this paper to fully explore this subject, a few observations are noteworthy.

First, because of the sheer number of growing elderly, health care costs will continue to rise. Programs sold on the basis of "reducing costs" will have, as we say in Arkansas, a tough row to hoe.

The second observation deals with the "alternatives vs. institutionalization" question. Many of us like to think community-based care programs are cheaper than institutionalization and thus a good buy. However, this does not seem to pan out. Two major factors account for this. Number one is the fact that for every person in a nursing home there are two or three in the community with the same type or level of impairment. Secondly, unless very tightly controlled and targeted, the aggregate costs of providing community-based care—even with a lower unit cost—are more than institutional care. Evaluations of the Section 222 Medicare and Section 1115 Medicaid waivers have revealed that in only two projects, South Carolina and On Lok, were the cost of waivered services lower than traditional institutionally oriented services (McConnel, 1985).

Does this mean community-based care should be abandoned? Hardly. It only means we must more precisely define its goals, objectives, outcomes and expectations. To remain in one's home is more desirable than to be placed in an institution. Should our nation's goal ever be anything less than to provide the most humane care possible? Perhaps providing community-based care is simply the right thing to do.

Furthermore, it has been well documented that the overwhelming majority of long-term care is provided by families. In fact, they make "Herculean and protracted efforts to provide long term care" (Kane, 1984). The *American Journal of Public Health*'s editorial "Home care for the Ill Elderly—Who Benefits?" argues that community-based care is needed, if for no other reason, than to lighten the burden on family

members who are doing their best to care for their own (Haug, 1985).

Finally, not every argument on cost effectiveness needs to be discarded. As stated earlier, two of the Waiver Projects were cost-effective. The study that prompted the above referenced editorial, reports that a home care team (which included a physician) costs no more than the traditional institutional-oriented service system, and in fact, may save a few dollars (Zimmer et al., 1985).

Whether or not community-based care is cost-effective might boil down to what state you live in, or even what county you live in. It has been a generally accepted health planning tool that 55 nursing home beds are needed for every 1,000 elderly persons (65+). Yet state bed/population ratios vary widely—from a low of 22 beds per 1,000 in Florida to a high of 94 in Wisconsin (U.S. Senate, 1983). Half of the states in our union have 60 or more beds per 1,000; eleven states have 70 or more beds per 1,000 (Applied Management Sciences, Inc. 1984). In Arkansas the number of nursing home beds per 1,000 varies in each county—from a low of 29 to a high of 154 per 1,000.

The answer to providing care in communities where an oversupply of nursing home beds exist is not more beds. Filling in service gaps with community-based care would be a more effective use of limited resources.

While community-based care in and of itself may not save dollars, it might be a prerequisite to a rational, controllable health care delivery system:

> A well established array of community services for the frail elderly creates the necessary conditions of public and professional confidence that allow purposeful control of the supply of nursing home beds. Developing community services and even offering expanded benefits for some such community-based services seem to have no immediate direct effect on the use (and therefore the cost) of nursing homes. Someone else in the large pool of potential users will take the nursing home bed. But the very existence of community programs creates the political conditions that permit constraining population ratios and improving the quality of institutional care by refusing to purchase it from facilities judged substandard. A current Rand study bears out these contentions. Once a community care system is in place, it is much easier to exert leverage over institutional supply and institutional use (Kane, 1984).

To meet the needs of a growing elderly population a comprehensive and coordinated long term community-based care system consisting of a continuum of services (care) must be designed. These terms are defined as follows:

Long-Term Care represents a range of services that address the health, social and personal care needs of individuals who, for one reason or another, have never developed or have lost some capacity for self care. Services may be continuous or intermittent, but it is generally presumed that they will be delivered for the "long term," that is, indefinitely to individuals who have a demonstrated need, usually measured by some index of functional incapacity.

Comprehensive The range of services incorporated into the system must be of sufficient scope, availability and accessibility to address the varied needs of the elderly population and to provide sufficient choice among services.

Coordinated Every reasonable means will be used to efficiently apply available resources in the most effective manner by coordinating the efforts of all actors in the community in the planning, funding, and actual delivery of service.

Community-based implies imbedding the concept and operations of the care system into the community infrastructure, such that there is general community awareness and support to the system and its ongoing operation.

Continuum of care, ensuring a client orientation pervades the system structure and operations. More specifically, ensuring the development of the capaicty to draw upon the comprehensive set of services on behalf of an individual client in an appropriate manner over time, successively redefining the mix of service made available to an individual in response to changing circumstances.

System, ensuring the concept of care involves an organized systematic means for defining, organizing, implementing,

Chart I

LONG-TERM SUPPORT SYSTEM

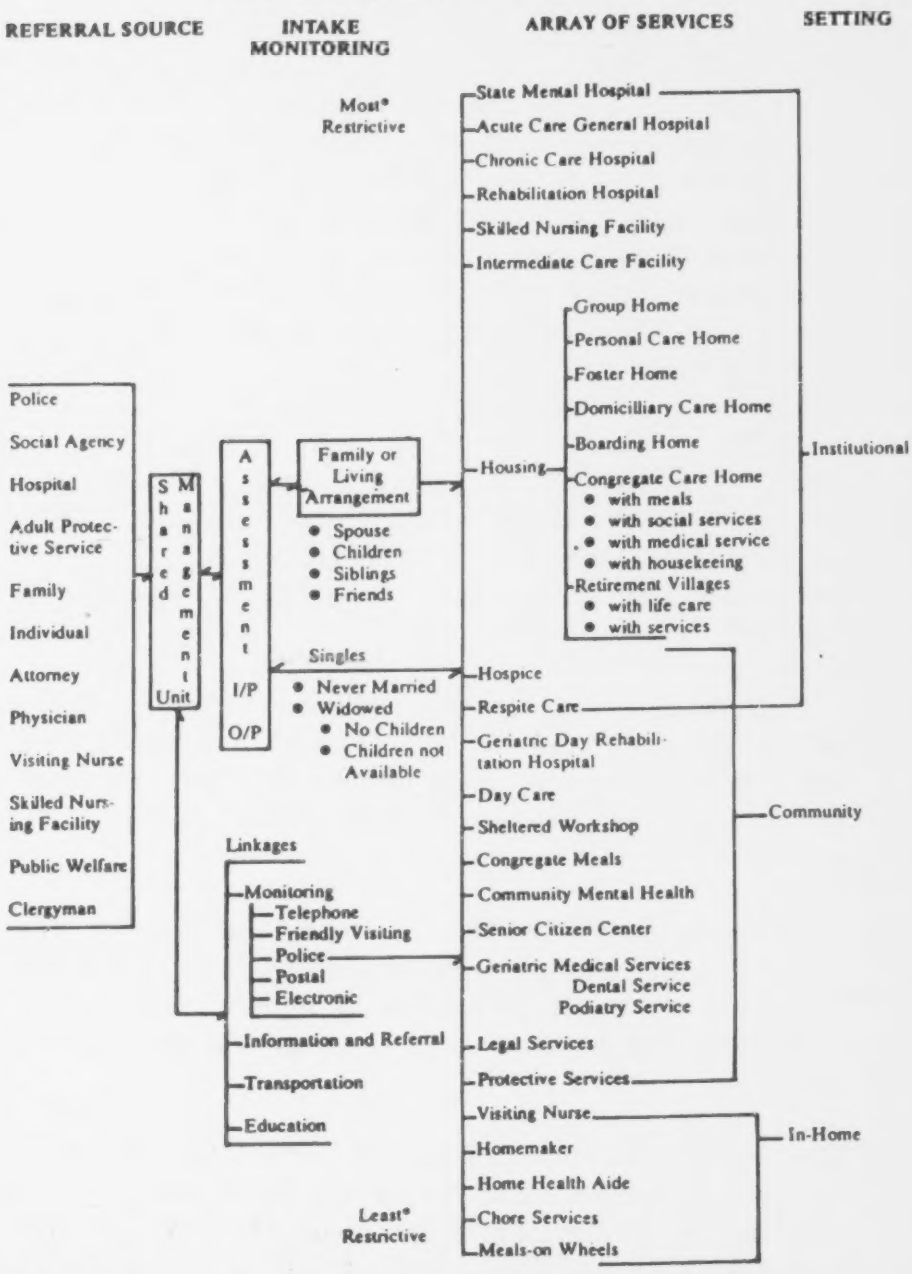

FIGURE 1—Inventory of Recommended Available Services, Appropriate to a Long-Term Care/Support System"

*"The classification of from most to least restrictive is a general view of services and may vary within each service.

Source: American Journal of Public Health, 1980.

operating, and successively evolving an appropriate services network. (White House Conference on Aging, 1980; The Assistance Group, 1980).

Stanley Brody and Carol Masciocchi have diagrammed what such a system should look like (Chart I). The system would have five goals:

1. Maximum functional independence at all times, even if there are limitations in activity or deterioration of function.

2. Rehabilitation, restoring him/her to some previous level of functioning which can be sustained.

3. Humane care for persons functionally and permanently dependent.

4. Utilization of the least restrictive environment.

5. Death with dignity for individuals in the dying process (Meltzer, 1981).

The development, implementation, and operation of the system described above will involve many actors. Increasingly, the future of our health care system is being shaped by the corporate enterprise; the influence of health planners, social service agencies, and government is diminishing. Paul Starr writes of this trend in his book *The Social transformation of American Medicine:*

> The rise of a corporate ethos in medical care is already one of the most significant consequences of the changing structure of medical care. It permeates voluntary hospitals, government agencies, and academic thought as well as profit-making medical care organizations. Those who talked about "health care planning" in the 1970s now talk about "health care marketing." Everywhere one sees the growth of a kind of marketing mentality in health care. And, indeed, business school graduates are displacing graduates of public health schools, hospital administrators, and even doctors in the top echelons of medical care organizations. The organizational culture of medicine

> used to be dominated by the ideals of professionalism and voluntarism, which softened the underlying acquisitive activity. The restraint exercised by those ideals now grows weaker. The "health center" of one era is the "profit center" of the next.
>
> No less important than its effect on the culture of medical care institutions is the likely political impact of the growth of corporate enterprise. As an interest group, the new health care conglomerates will obviously be a powerful force . . . The corporate health services industry will also represent a powerful new force resisting public accountability and participation.
>
> A corporate sector in health care is also likely to aggravate inequalities in access to health care. Profit-making enterprises are not interested in treating those who cannot pay . . . A system in which corporate enterprises play a larger part is likely to be more segmented and more stratified. With cutbacks in public financing coming at the same time, the two-class system in medical care is likely to become only more conspicuous . . . Instead of public regulation, there will be private regulation, and instead of public planning, there will be corporate planning. Instead of public financing for prepaid plans that might be managed by the subscribers' chosen representatives, there will be corporate financing for private plans controlled by conglomerates whose interests will be determined by the rate of return on investments. That is the future toward which American medicine now seems to be headed (Starr, 1982).

To put it in street vernacular, these new actors are playing hardball and they're playing for keeps. Is the aging network ready to play? If not, who then will represent Older Americans?

This author perceives several ways the aging network can more aggressively be involved in the development of a long term care system that will benefit the elderly. These have been grouped under three general headings.

1. Capacity Building

(a) For several years now the states have been required to use not less than one-percent of their funds allotted under Title III of the Older Americans Act for the Long-Term Care Ombudsman Program. This has proved to be a worthy cause. Most states, because of this mandate, have well-established ombudsman programs. Many states have passed legislation in this area.

Now that these programs are well rooted, why not replace the requirement that the states spend one-percent of Title III on Ombudsman activities, with a requirement that the one percent be spent on fostering a long-term care system?

Regardless of whether this policy is ever adopted, State and Area Agencies on Aging must staff up for long-term care. This could be done through new funding (discussed later) or by reassignment.

(b) How much money does the network spend monitoring, evaluating and assessmenting? How much of it produces a measurable, meaningful outcome that translates into better services? State units and AAA's each definitely have responsibilities in monitoring and assessment; it must be carried out. But, is the same level of effort required in 1985 as was seven, five, or two years ago? Perhaps, some of these resources could be redirected towards long-term care efforts.

I am also struck by the fact that I have received no less than five letters from other states asking for a copy of our assessment procedures. (Our state has not been much help with the requests because we also are trying to rework our assessment procedures.) This means that at least ten percent of the state units are working on the same basic task. How much time are we spending reinventing the same wheel? The same observation would probably hold true for AAA's. As the network matures, can we not find a more efficient way to deal with common initiatives and redirect savings to other areas such as long-term care?

(c) Capacity building might mean new staff, with different backgrounds. Go to a hospital and visit the comptrollers and social work offices (not the staff, but just the offices). Compare (a) which furniture and decorations you like best and (b) which office is located closer to the administrator. Seriously, we must realize that long-term care involves mega-dollars. Rate struc-

tures, bed standards, PPO's, HMO's, case management all have ominous financial overtones. Perhaps the next employee you hire should be a MBA instead of a MSW.

(d) The network needs to provide intensive training to existing staff. The skills, abilities, and knowledge of the existing network staff is desperately needed by the health care sector. Many program and policy decisions that work against the elderly are made not out of malace to elderly, but out of ignorance. The network needs to communicate with Medicaid agencies, State Health Coordinating Councils, hospitals, legislative committees, etc. But, we must speak their language. Perhaps it would be worth the investment for each state to organize a one-week training session for key staff on long-term care issues. In addition to using traditional trainers from the field of gerontology, faculty from health care administration or business administration schools should also be involved.

(e) On an ongoing basis, network staff must begin to read the literature. Long-term care issues are developing rapidly. They are complex and require careful and thoughtful analyses. Keeping abreast of developments is essential.

Knowledge is power; the network needs both.

2. Advocacy

(a) Advocacy is one of the major responsibilities of the aging network. Congress, in amending the Declaration of Objectives of the Older Americans' Act (OAA), added the following underlined phrases to objectives 4, 8, and 10:

> (4) Full restorative services for those who require institutional care, *and a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities and in their homes.*
>
> (8) Efficient community services, including access to low-cost transportation, which provide a choice in supported living arrangements and social assistance in a coordinated manner and which are readily available when needed, *with emphasis on maintaining a continuum of*

care for the vulnerable elderly.

(10) Freedom, independence, and the free exercise of individual initiative in planning and managing their own lives *and full participation in the planning and operation of community-based services and programs provided for their benefit.*

(b) The Act also requires Area Agencies on Aging (AAA's), through their area plans, to "conduct efforts to facilitate the coordination of community-based, long-term care services designed to retain individuals in their homes, thereby deferring unnecessary, costly institutionalization, and designed to emphasize the development of client-centered case management systems as a component of such services."

(c) While OAA regulations may no longer require a public hearing, they certainly do not prohibit them. Perhaps the network should convene a town hearing in every county of the United States on the need for a community-based long term care system. No doubt, one of the obstacles to community-based care is a lack of knowledge about it. It is difficult to expect the public to support respite care and day care if they do not know what the terms mean. Such meetings should be aimed at responsible family members as well as actual users of the system.

(d) Several states have found Silver-Haired Legislative sessions to be an effective advocacy tool. These sessions could be expanded to consider long-term care issues.

(e) Governor's Advisory Councils as well as AAA Advisory Councils, if properly supported and staffed, can be effective advocates for long-term care reform.

(f) A state unit or AAA may wish to convene their own "Blue-Ribbon Committee" of respected community leaders to examine the issue of community-based long-term care.

(g) Support and involvement in National Association of State Units on Aging and National Association of Area Agencies on Aging respective positions is both educational and productive.

3. Programs

(a) There are state units in every state of the union and over 660 Area Agencies on Aging. Why look to developing a new bureaucracy to provide case management services? Rosile Kane makes an excellent case for using AAA's for case management (Kane, 1984).

(b) Some AAA's already act as case managers and are ready to move forward. These agencies may want to become brokers, coordinating services between hospitals, Health Maintenance Organizations (HMO's), Preferred Provider Organizations (PPO's) and existing providers of services, e.g., home-delivered meal programs. Because hospitals will be able to discharge clients earlier or because HMO's need transportation to keep clients there healthy, they will be willing to pay a fee for this brokerage service. Structuring such a service may not be easy and might involve risk, but the days for picking up the *Federal register* and seeing what new grant is being announced are over.

(c) For some areas of the country there may be no services to case-manage, much less broker. In these instances, the AAA may need to become a service provider, or spin off another corporation to provide services.

(d) Finally, while new money is harder to come by, it is not impossible to come by. All state units, AAA's and service providers have the potential for capital formation. For example, by dedicating 10 Title V workers to an in-home care project, one can in effect form capital. It may not be a great deal of money, but it certainly can prove the effectiveness of a service on a demonstration basis. Service providers under a unit rate reimbursement system, because they are put at risk have a potential to create capital in the form of "unrestricted fund balances." These funds can be used to hire new planners and MBA's or to provide new service.

Perhaps it would not be impossible for a state unit to convince their governor or legislature to devote one tenth of one percent of their nursing home budget to study the use of alternatives to institutionalization. (Calculate this for your state; you might be surprised.)

(e) Perhaps there are indeed new sources of funding

available to be tapped that would infuse substantial amounts of money into a community-based long-term care system. For example, cigarette taxes: according to the July, 1984 Monthly State Cigarette Tax Report published by the Tobacco Institute, the average state tax on cigarettes is 15.75¢ per package. If you exclude the three lowest states (which happen to be major tobacco producers) the average tax rises to 16.60¢ for the remaining 47 states. If aging interests could convince a state like Mississippi (11¢ per pack state tax) to raise their cigarette tax to the 16.60¢ average, with proceeds going for long-term care, $18,000,000 would be generated for new services.

Severance taxes may be another area worth examining. Undeniably, state lotteries are becoming more and more popular. Look at the budget of the Pennsylvania Office on Aging to see the potential for new revenues from a state lottery.

None of these are quick and easy sources of funds. All have special interests that will work hard against any move into "their territory." But what network has more potential power than the aging network?

These ideas are presented as concepts. They are not universal in their application. There are other ideas that are not listed.

Because our nations health-care system is at the crossroads, the aging network is also. We can shape our future—if we choose to do so.

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Senator PRYOR. Thank you very, very much. Our next witness is Dr. Roger Busfield. Thank you, Roger.

STATEMENT OF ROGER BUSFIELD, M.D., LITTLE ROCK, AR, DIRECTOR, ARKANSAS HOSPITAL ASSOCIATION

Dr. BUSFIELD. Thank you, Senator. The Arkansas Hospital Association has not adopted an official position on the catastrophic and long-term coverage. We have reviewed carefully the recommendations of the American Hospital Association with which we are affiliated, as these recommendations may affect health care delivery in Arkansas. If our Arkansas hospitals were not presently absorbing as charity or bad debts significant amounts for patients with chronic illnesses or injuries who can no longer pay their bills, the need for catastrophic coverage would be even much more acute. For example, it's not uncommon for our hospitals to write off bills of $20,000 to $60,000 or more because the patient and his or her family had exhausted all of their resources. Senator, in line with that, I have, with the names of the patients eliminated, from one hospital in the central Arkansas area, St. Vincent Infirmary, several dozens of examples of just what I'm referring to that you can have for the record of your committee.[1]

Senator PRYOR. Thank you, Dr. Busfield.

Dr. BUSFIELD. However, what's facing our hospitals is an inability to spread these uncompensated costs to other payers, as we have been able to do and have been doing for many years. As Medicare and Medicaid cut back on what they will pay for a patient, other third-party payers have done the same thing or are in the process of doing so.

Therefore, any comprehensive solution to the problem of catastrophic illness must address the three causes of catastrophic expenses: One, inadequate Medicare coverage of catastrophic acute care costs. Two, even more inadequate public and private coverage of long-term care costs; and, third, the presence of large numbers of uninsured and underinsured in the non-Medicare population. The AHA recommendations fall in all these three areas.

Regarding catastrophic acute care, Medicare should continue to provide universal coverage for the elderly and disabled. Eligibility should not be tied to beneficiary income but should be tied to the age of eligibility for Social Security benefits.

To address catastrophic expenses resulting from inadequacies in the current Medicare benefit package, several changes should be made. Unlimited inpatient hospital care should be covered; the current limitations on coverage should be eliminated. Coverage should be extended to prescription pharmaceuticals, which at the present time are not covered by Medicare. Prescriptions are covered by Medicaid, but not by Medicare. The restrictions on coverage of home health and skilled nursing services should be revised to permit beneficiaries to make use of less expensive alternatives to inpatient acute or long-term care. For example, by relaxing the intermittent care and homebound requirements for home health

[1] See p. 84.

services and the 3-day prior hospitalization service requirement for SNF service.

The current system of copayment should be replaced by requirements that establishes positive consumer incentives and that are sensitive to the differences in beneficiary income. Combined expenditures for covered services should exceed an annual deduction before Medicare begins to provide coverage. But after the annual deductible has been satisfied, a uniform percentage copayment should be applied to all covered services subject to an annual out-of-pocket limit. Now, once the annual out-of-pocket limit is reached, no additional copayment should be required. The annual out-of-pocket limit should vary with beneficiary's income. The annual out-of-pocket limit should apply to total out-of-pocket expenses, including the deductible. Thus, a low-income beneficiary may be required to satisfy only a very low annual deductible, after which Medicare would pay for all care.

Individual medical accounts, which the Senator has mentioned, are a means of encouraging Medicare beneficiaries to accumulate sufficient savings to purchase supplemental coverage. The financing of long-term care, including skilled nursing facilities, intermediate care facilities, home care, and custodial nursing home care, has been and will probably continue to be a shared responsibility of individuals, the private sector and State and Federal Government. The goals of public policy should be to encourage individuals to make provision for long-term care needs to the extent permitted by their income, but to provide access to needed long-term care when individual resources are inadequate; and to establish a more humane alternative to the spend down requirements.

Finally, you must never forget that long-term care is the leading cause of catastrophic medical expenses among the elderly. Out-of-pocket expenditures by patients and their families are the most important source of financing for long-term care. Medicare covers only limited, post acute skilled nursing care, while Medicaid covers extended care at a skilled nursing, intermediate, and custodial level so to qualify for Medicaid coverage, unfortunately, it's necessary to spend down savings and investments, including investments in a family home. Thus to qualify for public assistance it is often necessary to first incur catastrophic expense.

Thank you for the opportunity.

[The prepared statement of Dr. Busfield follows:]

STATEMENT OF ROGER M. BUSFIELD, JR.
PRESIDENT
ARKANSAS HOSPITAL ASSOCIATION
ON CATASTROPHIC AND LONG TERM CARE INSURANCE COVERAGE
before the U.S. SENATE COMMITTEE ON AGING
AUGUST 28, 1986

I am Roger Busfield, President of the Arkansas Hospital Association in Little Rock. Our Association represents 104 Arkansas healthcare institutions. We are an affiliate organization of the American Hospital Association. I welcome the opportunity to testify at this hearing. The Arkansas Hospital Association has not adopted an official position on catastrophic and long term care coverage. We are concerned about the subjects at hand and we have reviewed carefully the recommendations of the American Hospital Association as they may effect health care delivery in Arkansas.

If our Arkansas hospitals were not presently absorbing as charity or bad debts significant amounts for patients with chronic illnesses or injuries who can no longer pay their bills, the need for catastrophic coverage would be much more acute. For example, it is not uncommon for our hospitals to write off bills of 20 to 60 thousand dollars or more because the patient and his or her family had exhausted all other resources.

However, what is facing our hospitals is an inability to spread these uncompensated costs to other payers—as they have been able to do for many years. As Medicare and Medicaid cut back on what they will pay for a patient, other third party payers have done the same thing or are in the process of doing so.

Therefore, any comprehensive solution to the problem of catastrophic illness must address the three causes of catastrophic expense: (1) inadequate Medicare coverage of catastrophic acute care costs, (2) even more inadequate public and private coverage of long term care costs, and (3) the presence of large numbers of uninsured and underinsured in the non-Medicare population. The AHA recommendations fall into these three areas.

I. Catastrophic Acute Care

Medicare should continue to provide universal coverage for the elderly and disabled. Eligibility should not be tied to beneficiary income, but should be tied to the age of eligibility for Social Security benefits.

To address catastrophic expenses resulting from inadequacies in the current Medicare benefit package, several changes should be made in the current benefit package:

--Unlimited inpatient hospital care should be covered; the current limitations on coverage should be eliminated.

—Coverage should be extended to prescription pharmaceuticals.

—The restrictions on coverage of home health and skilled nursing services should be revised to permit beneficiaries to make use of less expensive alternatives to inpatient acute or long-term care, E.G., by relaxing the intermittent care and home-bound requirements for home health services, and the three-day prior hospitalization requirement for SNF services.

The current system of copayment should be replaced by requirements that establish positive consumer incentives and that are sensitive to differences in beneficiary income

—Combined expenditures for covered services should exceed an annual deductible before Medicare begins to provide coverage.

—After the annual deductible has been satisfied, a uniform percentage copayment should be applied to all covered services, subject to an annual out-of-pocket limit.

—Once the annual out-of-pocket limit is reached, no additional copayment should be required.

—The annual out-of-pocket limit should vary with beneficiary income.

The annual out-of-pocket limit should apply to total out-of-pocket expenses, including the deductible. Thus, a low income beneficiary may be required to satisfy only a very low annual deductible, after which Medicare would pay for all care. Supplemental insurance covering required co-payments and non-covered services should continue to be available through private insurers.

Basic Medicare benefits should continue to be funded on a pay-as-you-go basis. Through Medicaid, Medicare should pay the Medicare premium and provide supplemental coverage of required coinsurance for Medicare beneficiaries receiving or eligible for supplemental security income (SSI).

Individual Medical Accounts (IMAs) are a means of encouraging Medicare beneficiaries to accumulate sufficient savings to purchase supplemental coverage, pay the Medicare premium and copayment amounts, purchase private long term care insurance, or pay for long term care. They cannot serve as a cornerstone for financing Medicare, but may reduce the need to use general revenues or payroll taxes to fund care, particularly long term care.

Offering beneficiaries the option of enrolling in qualified private health plans, which combine the financing and delivery of care and are paid on a capitation basis, has potential as a means of providing catastrophic coverage at lower total costs to the program and beneficiaries. The expansion of these alternatives may be limited in the short-term by the absence of actuarially sound methods of computing premiums or voucher amounts for individuals and small groups.

Universal coverage creates a strong base of political support for the program and spreads

risk across the entire population. Limiting coverage on the basis of income presupposes the availability of private insurance to the elderly, and would necessitate complex eligibility tests, including spend down requirements.

2. Long Term Care

The financing of long term care (including Skilled Nursing Facility, Intermediate Care Facilities, home care and custodial "nursing Home" care) has been, and will continue to be, a shared responsibility of individuals, the private sector, and state and federal government. The goals of public policy should be: to encourage individuals to make provision for long term care needs to the extent permitted by their income; to provide access to needed long term care when individual resources are inadequate; and to establish a more humane alternative to spend-down requirements.

—The development of private sector alternatives for financing long term care should be encouraged through tax incentives and demonstration projects supported by both the public and private sector. IMAs might be structured as a type of long term care insurance. These initiatives should include efforts to increase understanding among the elderly and non-elderly of the need for an cost of long term care.

— For the population dependent upon public assistance, public programs should stress keeping patients out of institutional settings, when appropriate, and should encourage innovation in the delivery of care to the chronically ill. The restructuring of Medicaid and creation of a distinct program of long term care coverage for low income Medicare beneficiaries would encourage such innovation.

— To protect the dependents of chronically ill individuals, and to reduce the risk of long-term dependency by those needing limited amounts of long term care, a federal/state program of loans could be established through which a family could "borrow" against a beneficiary's estate to meet the cost of long term care

(including skilled nursing, intermediate and custodial care) for an institutionalized family member. In the case of couples, the non-institutionalized spouse would retain the use of the assets until his or her death.

We must never forget that long term care is the leading cause of catastrophic medical expenses among the elderly. Out-of-pocket expenditures by patients and their families are the most important source of financing for long term care. Medicare covers only limited, post-acute skilled nursing care, while Medicaid covers extended care at the skilled nursing, intermediate, and custodial levels. To qualify for Medicaid coverage, it is necessary to "spend down" savings and investments, including investments in a family home. Thus, to qualify for public assistance, it is necessary to incur catastrophic expenses.

3. Catastrophic Illness and the Non-Medicare Population

Concern over the problem of catastrophic illness among the Medicare population, should not draw attention away from the significant problem of medical indigence in the non-Medicare population. Any significant illness is "catastrophic" for individuals who are unable to purchase private health insurance. To address the issue of underinsurance, insurers and employers should make information on the cost and potential value of catastrophic coverage more widely available, and federal policies should encourage the coverage of catastrophic illnesses by private insurance.

Again, thank you for the opportunity to address the Committee.

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: JULY 24, 1986

RE: PATIENT: [redacted]
PATIENT NUMBER:
DATE OF SERVICE: JAN. 14 - MAY 3, 1985
BALANCE AT DISCHARGE: $ 96,875.09
BALANCE AFTER INSURANCE: $ 11,528.46

[redacted] WAS A PREMATURE NEWBORN WHO SPENT HER FIRST FIVE MONTHS IN THE INTENSIVE CARE NURSERY. SHE EXPIRED AT HOME ON JUNE 29, 1985.

[redacted] IS A SALESMAN FOR [redacted] INSURANCE COMPANY AND EARNS ABOUT $800.00 PER MONTH. THE [redacted] ARE UNDER HEAVY FINANCIAL STRAIN AT THIS TIME DUE TO SEVERAL TRAGEDIES IN THE PAST TWO YEARS. IN 1984, THEIR HOME BURNED AND THEY WERE UNABLE TO SALVAGE ANYTHING. [redacted] WAS BORN 2 MONTHS PREMATURE IN 1985. AFTER [redacted] DEATH, MRS. [redacted] LOST HER JOB AT A DAY CARE CENTER. FROM CONVERSATIONS I HAVE HAD WITH MRS. [redacted], I FEEL SHE PROBABLY "FELL APART" AT THE DAY CARE CENTER AND THEY HAD NO CHOICE BUT TO LET HER GO.

THE [redacted] HAVE TWO OTHER CHILDREN ALSO, AGED 2 AND 3. MRS. [redacted] SEEMS TO BE HAVING A DIFFICULT TIME EVEN TAKING CARE OF HER FAMILY AND PROBABLY WILL NOT BE ABLE TO WORK, ALTHOUGH SHE HAS BEEN LOOKING FOR A JOB. ON THE TELEPHONE, MRS. [redacted] APPEARS TO BE UNABLE TO COPE WITH ALL THAT HAS HAPPENED IN THE PAST TWO YEARS. SHE BLAMES THE DOCTOR FOR [redacted] DEATH AND EVEN NOW, A YEAR LATER, CRIES WHEN I TALK TO HER.

THE [redacted]' DID HAVE INSURANCE WHICH HAS PAID 65% OF THIS INPATIENT STAY AND ALL OF A SEPARATE OUTPATIENT VISIT. THEY HAVE NO FINANCIAL RESOURCES: THEIR TRAILER IS FINANCED AND THEY ARE IN DANGER OF HAVING THIS REPOSSESSED. THEIR AUTO IS A 1977 PLYMOUTH.

PLEASE CONSIDER THIS $11,528.46 FOR CHARITY.

7/29/86

7-28-86
Mr Dingler:
I Recommend that
this dol. for $11,528.46 Be
handled as "Charity"
Vol B

MEMORANDUM

St. Vincent Infirmary
FAUST VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5484
TELEPHONE (501) 660-3000

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: AUGUST 18, 1986

SUBJECT: [redacted] (EXP), [redacted], June 13-23, 1985
ORIGINAL CHARGES: $16,212.77 NET TO CONSIDER FOR CHARITY: $6,235.71

Mrs [redacted] was a 71 year old widow who expired at SVI on June 23, 1985 with a diagnosis of heart blockage. She had been here for ten days, nine of which were in CCU.

Mrs. [redacted] was covered by Medicare Part B only and by Medicaid. Both have paid on this account. Medicaid covered only five of the ten day stay.

Prior to hospitalization, Mrs. [redacted] lived with her son. Mrs. [redacted] daughter telephoned to say there was no estate.

8-20-86
Pat died leaving nothing -
I suggest charity w/o -

V. Rowlett

6/26/87

MEMORANDUM

St. Vincent Infir.
TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5
TELEPHONE (501) 660-3000

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: AUGUST 18, 1986

SUBJECT: [redacted] (Exp), [redacted], August 11 - October 4, 1985
BALANCE AT DISCHARGE: $54,420.18 CURRENT BALANCE: $ 7,597.00

[redacted] was brought here immediately after birth and remained in the ICN unit u her death on October 4, 1985.

Her parents had Time Insurance which paid $ 46,823.18 on the account. Randy Cox in Soci Services worked with Mr. and Mrs. [redacted] and Medicaid did finally approve in January, 1986. However, Medicaid paid nothing on the account due to the large sum that insuranc had already paid.

Mr. [redacted] is a self-employed farmer and his income is sporadic. Mrs. [redacted] does no work outside the home. This young couple is barely making it now with heavy bills and a variable income.

8-20-86
Mr Dingler
A Charity w/o Appears
to be at Disposition of this
Acct -

8/24/81

MEMORANDUM

St. Vincent Infirmary
TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 660-3000

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: AUGUST 18, 1986

SUBJECT: [redacted], 9/2 - 27/85
Original Charges: $15,277.97 Balance after Medicaid: $7,488.55

Ms. [redacted] is 50 years old and disabled. She was an inpatient at SVI for 25 days with a diagnosis of Congestive Heart Failure.

Ms. [redacted] was eligible for Medicaid which only covered seven days of this stay. The patient made one $20.00 payment before applying for Uncompensated Services.

Ms. [redacted] receives $336.00 per month in SSI benefits. She is single and this is her only source of income. There are no resources to apply towards this balance.

8-20-86
Mr Riggin
Patient has w/bid which pays
approx 1/2 of his charges
Doing NO Alg. Chg to Pay
Arr. Wingon Thoughout
I Recommend Write off -
Rowlett

RF 8/26/86

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM
AUGUST 15, 1986

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

RE: CHARITY APPLICATION: [redacted])
ACCOUNT NUMBER: [redacted]
DATE OF SERVICE: DECEMBER 3 - 13, 1985
ORIGINAL CHARGES: $ 22,013.00
BALANCE AFTER MEDICAID PAYMENT: $ 17,990.06

MRS. [redacted] WAS A 62 YEAR OLD WIDOW WHO WAS AT ST. VINCENT INFIRMARY ON SEVERAL OCCASIONS WITH CARDIAC-RELATED DIAGNOSES. SHE EXPIRED ON DECEMBER 13, 1985.

MRS. [redacted] WAS APPROVED FOR MEDICAID WHICH COVERED THE FIRST EIGHT DAYS OF HER STAY. UNFORTUNATELY, SURGERY WAS NECESSARY THE LAST TWO DAYS OF HER HOSPITALIZATION RESULTING IN THE ABNORMALLY HIGH BALANCE AFTER MEDICAID PAYMENT.

MRS. [redacted] SIGNED THE CONDITIONS OF ADMISSION HERSELF. THERE WOULD BE NO FINANCIAL RESOURCES TC PURSUE FOR PAYMENT OF THIS BALANCE SINCE MRS. [redacted] WAS ELIGIBLE FOR MEDICAID WITH ITS VERY STRINGENT RULES OF INCOME AND ASSETS.

JDO

8-20-86

Mr. Rowlett:
I Recommend a charity
write As the only practical
Disposition of this debt.

8/26/86

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: AUGUST 15, 1986

RE: PATIENT: [redacted]
PATIENT NUMBER: [redacted]
DATE OF SERVICE: MAY 27 - JULY 8, 1985
BALANCE AT DISCHARGE: $ 19,300.77

MR. [redacted] IS A 20 YEAR WHO DOVE INTO FOUR FEET OF WATER INJURING HIS NECK. HE WAS BROUGHT TO SVI FROM [redacted] HOSPITAL.

EVEN PRIOR TO THIS ACCIDENT, MR. [redacted] ONLY WORKED SPORADICALLY. HE LIVED, AS HE DOES NOW, WITH HIS PARENTS WHO PROVIDE HIS LIVING EXPENSES OF ROOM AND BOARD.

NEITHER THE PATIENT NOR FAMILY APPEAR EDUCATED. SOCIAL SERVICES WORKED WITH THEM TO TRY AND GET HELP. MEDICAID DENIED SINCE MR. [redacted] WAS OVER 18. MEDICARE SOCIAL SECURITY DISABILITY DENIED AS HE WAS NOT CONSIDERED DISABLED.

MR. [redacted] FRACTURED HIS NECK AND HAD OTHER COMPLICATIONS RESULTING IN A SIX WEEK STAY AT SVI. HIS FAMILY DOES NOT HAVE THE FINANCIAL RESOURCES TO PAY AN ACCOUNT OF THIS SIZE. IT IS ALSO DOUBTFUL THAT MR. [redacted] WILL SOON HAVE THE INCOME CAPABILITY TO PAY ON THIS ACCOUNT.

8-20-86
Mr. Dugan

From what we know of of the pt's fin situation, I don't believe collection action would be productive. I recommend Charity 100%.

8/26/86

[redacted] DILLING STATUS 08/21/86 1304
[redacted] CASE NO [redacted] MEDICAL RECORD [redacted]
DISCHARGED ADMISSION DATE 04/03/86 DISCHARGE DATE 04/[illegible]/86
FINANCIAL CLASS 04

MEMORANDUM.....AUGUST 21, 1986

TO....ELDON DINGLER RE [redacted]
CHARITY RECOMMENDATION $3,695.69 TOTAL CHGS.-NO PMTS

BEFORE THE PATIENT WAS ADMITTED ON 4-3-86, MR. REYNOLDS CALLED ME AND STATED THAT DR. GLENN DAVIS HAD TALKED TO HIM ABOUT THIS PATIENT. STATED THAT PAT. H NO MONEY, INSURANCE, ETC. BUT NEEDED TO BE HOSPITALIZED. OF COURSE, WE ADMITTI HER WITH NO DEPOSIT AND THERE HAVE BEEN NO PAYMENTS ON THE ACCOUNT. I TALKED TO PATIENT ON 5-13-86. SHE STATED THAT SHE HAD APPLIED FOR EVERY PUBLIC ASSIS TANCE PROGRAM THAT SHE KNEW OF AND HAD BEEN TURNED DOWN. SHE STATED THAT SHE HAD NO INCOME AT ALL, THAT SHE WAS JUST ABOUT OUT OF FOOD. SHE CRIED WHILE TALKING TO ME AND ASKED IF I KNEW OF ANY SOURCE OF HELP. MY ONLY SUGGESTION WAS TO GO BACK TO THE STATE SOCIAL SERVICE OFFICE IN PHILADELPHIA AND ASK AGAIN FOR HELP. FROM THE LETTER I RECEIVED FROM HER TODAY, IT LOOKS LIKE SHE HAS BEEN TRYING TO GET SOME HELP. SHE SAYS THAT SHE HASN'T WORKED IN OVER A YEAR DUE TO SOME DIGESTIVE DISORDER THAT SHE HAS. I REALLY NEVER COULD UNDERSTAND FROM HER JUST HOW SHE WAS SURVIVING AT ALL.

I SUGGEST THAT WE WRITE THIS OFF TO CHARITY AND IF SHE DOES BECOME APPROVED FOR MEDICAID OR SOME OTHER PROGRAM THAT WILL PAY ALL OR PART OF THIS BILL, WE CAN ALWAYS GO BACK AND REVERSE THE CHARITY WRITE OFF IN THE AMOUNT OF THE PAYMENT.

8/21/86

MEMORANDUM

St. Vincent Infirmary
TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5484
TELEPHONE (501) 660-3000

TO: Vol B. Rowlett

FROM: Joyce Overton

DATE: August 19, 1986

SUBJECT: [redacted], PN [redacted], DOS January 19-24, 1986
Total Charges of Account: $ 2,007.03

Mrs. [redacted] was at SVI for 5 days with a diagnosis of cancer. At the time she was an inpatient, she was 64 years old. She applied for Medicaid but was not approved. She is now 65 and eligible for Medicare coverage.

Mr. [redacted] is 71 years old and retired. Their Social Security benefits of $700.00 must go to meet all their living expenses which they report at $658.45 monthly plus annual expenses.

The [redacted] have no resources to apply towards this account. They live in a mobile home and state their car is a 1978.

E-20; DE
Mr. Hinyen:
I suggest 19 charity
Thx -

6/26/86

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM 8-13-86

Ms Dingler
I Recommend Char
2/6 of this Acct -
Dol Rowlett

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON JO

DATE: JULY 31, 1986

RE:

PATIENT:	[redacted]
PATIENT NUMBER:	[redacted]
DATE OF SERVICE:	JANUARY 29 - FEBRUARY 7, 1986
BALANCE AT DISCHARGE:	$ 3,660.94
BALANCE AFTER MEDICAID:	$ 511.90

MRS. [redacted] IS A 54 YEAR OLD WOMAN WHO WAS HERE NINE DAYS IN FEBRUARY. SHE WAS ADMITTED WITH MULTIPLE DIAGNOSES INCLUDING ANEMIA, GASTRITIS, AND BLOOD DISEASE.

THERE ARE FIVE IN THIS FAMILY, TWO OF WHICH ARE DEPENDENT CHILDREN RECEIVING AN AFDC MONTHLY CHECK OF $192.00. MRS. [redacted] IS ON SSI WITH A MONTHLY CHECK OF $335.00 MAKING A TOTAL MONTHLY INCOME OF $527.00. THIS GOES TO MEET THEIR SHELTER AND FOOD COSTS.

MRS. [redacted] IS COVERED BY MEDICAID WHICH HAS PAID THEIR MAXIMUM BENEFIT FOR THIS STAY. TWO DAYS WERE NOT COVERED BY MEDICAID LEAVING A BALANCE DUE OF $511.90.

MRS. [redacted] HAS NO FINANCIAL RESERVES TO APPLY TOWARDS THIS ACCOUNT.

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

M E M O R A N D U M
JULY 30, 1986

TO: VOL B. ROWLETT FROM: JOYCE OVERTON JO

RE: CHARITY APPLICATION: [redacted]
ACCOUNT NUMBER: [redacted]
DATE OF SERVICE: DEC 31,1985 - JAN 11, 1986
ORIGINAL CHARGES: $ 5,541.77
BALANCE AFTER MEDICAID PAYMENT: $ 2,236.88

MRS. [redacted] IS A 47 YEAR OLD DIVORCEE WHO WAS HERE FOR 17 DAYS WITH A DIAGNOSIS OF ACUTE BRONCHITIS.

MRS. [redacted] IS DISABLED AND RECEIVES SOCIAL SECURITY BENEFITS OF $482.00 PER MONTH. SHE ALSO RECEIVES $200.00 MONTHLY FOR HER DEPENDENT CHILD. MEDICARE COVERAGE BEGAN ON MARCH 1, 1986 AFTER THIS INPATIENT STAY.

MRS. [redacted] WAS ELIGIBLE FOR MEDICAID WHICH HAS PAID ON THIS ACCOUNT HOWEVER, MEDICAID ONLY PAID FOR 7 DAYS OF THIS ADMISSION LEAVING THE CURRENT UNPAID BALANCE.

MRS. [redacted]S INCOME ONLY MEETS HER ROUTINE LIVING EXPENSES. SHE REPORTS NUMEROUS MEDICAL EXPENSES INCLUDING AN ACCOUNT AT ISF. IN CHECKING, I FIND THAT SHE IS PAYING ON THIS ACCOUNT BUT QUITE ERRATICALLY: $10 - $15 EVERY OTHER MONTH OR SO. (THIS ACCOUNT IS ON HER DAUGHTER AND HAS A BALANCE OF $220.) IN LOOKING OVER HER UNCOMPENSATED WORKSHEET, ONE MIGHT THINK MRS. [redacted] COULD MAKE MONTHLY PAYMENTS ON THIS ACCOUNT, BUT SHE IS PROBABLY PAYING ALL HER BILLS LIKE THE ONE AT ISF, I.E. NOW AND THEN.

SHOULD THIS WRITE OFF PROMOTE GOOD GUEST RELATIONS WHICH BRINGS MRS. ALLEN BACK TO SVI FOR NECESSARY MEDICAL ATTENTION, HER ACCOUNTS WILL BE COVERED 100% SINCE SHE NOW HAS BOTH MEDICARE AND MEDICAID.

8-13-86
Mr Dillon:
I Recommend charity w/o of This Acct
Lowlett

AP 8/21/86

St. Vincent Infirmary

[redacted]
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) [redacted]

MEMORANDUM

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: MAY 30, 1986

RE: CHARITY APPLICATION: [redacted] (EXP)
PATIENT NUMBER: [redacted]
DATE OF SERVICE: 12/16/85 - 01/30/86
BALANCE AT DISCHARGE: $ 41,082.91
BALANCE AFTER MEDICAID: $ 36,978.99

MR. [redacted] WAS A 23 YEAR OLD MAN WHO WAS ADMITTED IN 1985 WITH A DIAGNOSIS OF CANCER OF THE BRAIN. HE EXPIRED AT SVI ON JANUARY 30, 1986.

MR. [redacted] HAD BEEN DETERMINED DISABLED AND WAS COVERED BY MEDICAID WHICH WAS BILLED FOR THIS STAY. MEDICAID ONLY COVERED 6 DAYS OF THE ADMISSION LEAVING 39 DAYS NON-COVERED.

ATTEMPTS HAVE BEEN MADE TO CONTACT MR. [redacted]'S WIDOW. HER TELEPHONE HAS BEEN DISCONNECTED AND WE HAVE BEEN UNABLE TO LOCATE HER. MR. [redacted]'S FAMILY STATES THAT MRS. [redacted] LEFT TOWN AFTER THE FUNERAL AND THEY DO NOT KNOW HER WHEREABOUTS.

MR. [redacted] HAD NO INSURANCE OTHER THAN MEDICAID AND LEFT NO ESTATE. HIS BROTHER IS ATTEMPTING TO PAY SOME OF THE MEDICAL BILLS BUT DOES NOT HAVE THE MEANS TO PAY AN AMOUNT OF THIS SIZE. (THE "CONDITIONS OF ADMISSIONS" WAS SIGNED BY MRS. [redacted].)

I DO NOT SEE ANY WAY WE CAN OBTAIN PAYMENT OF THIS ACCOUNT AND REQUEST YOU CONSIDER THIS $36,978.99 FOR CHARITY.

JDO

Joyce
AR
6/2/86

5-30-86
Abe Rowden:
I feel that under the
Dept. of Charity is the
most practical disposition
of this large balance.
Rowlett

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM

Mr Douglas Hammond
Charity A/R on
the desk
Please

TO: GEORGE FLEMING

FROM: JOYCE OVERTON

DATE: APRIL 25, 1986

RE: CHARITY APPLICATION: [redacted]
ACCOUNT NUMBER: [redacted]
DATE OF SERVICE: SEPTEMBER 23 - 26, 1984
ORIGINAL BALANCE: $ 2599.53

MRS. [redacted] IS A 60-YEAR OLD WOMAN WHO WAS ADMITTED TO SVI THROUGH THE EMERGENCY ROOM WITH CHEST PAINS. SHE WAS IN CCU FOR ONE DAY AND STAYED TWO DAYS IN A SEMI-PRIVATE.

MRS. [redacted] HAD NO INSURANCE. SHE MADE APPLICATION FOR MEDICAID BUT WAS DENIED DUE TO NOT BEING DETERMINED PERMANENTLY AND TOTALLY DISABLED.

MRS. [redacted] HUSBAND, [redacted] RECEIVES $332.00 PER MONTH IN SOCIAL SECURITY PAYMENTS. THIS GOES TO PAY THEIR UTILITIES, MEDICATIONS, AND MISCELLANEOUS EXPENSES.

MR. AND MRS. [redacted] DO OWN THEIR HOME ($5000 VALUE) AND A TRUCK THAT SHE STATES IS WORTH ABOUT $200. MRS. [redacted] IS QUITE FEARFUL OF THEIR HOME BEING TAKEN AWAY FROM THEM: APPARENTLY THE HOME IS ALL THEY OWN.

PLEASE CONSIDER THIS $2599.53 BALANCE FOR CHARITY WRITE OFF.

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM
JUNE 24, 1986

TO: VOL B. ROWLETT FROM: JOYCE OVERTON

RE: CHARITY APPLICATION: [redacted] (EXP)
PATIENT NUMBER: SEE BELOW
BALANCE AT DISCHARGE ALL ACCOUNTS: $ 56,576.76
BALANCE TO CONSIDER FOR CHARITY: $ 46,172.77

MR. [redacted] WAS A 40 YEAR OLD MAN WHO WAS AN INPATIENT FIVE TIMES AT SVI IN 1985. HIS ORIGINAL VISIT WAS TO ER DUE TO BACK PAINS. AFTER TESTING IN EP, MR. [redacted] WAS ADMITTED WITH A DIAGNOSIS OF CANCER. MR. [redacted] WAS MARRIED; HE AND HIS WIFE WERE EXPECTING THEIR FIRST CHILD AT THE TIME OF THIS INITIAL HOSPITALIZATION. THE [redacted] HAD BUILT UP THEIR SAVINGS ACCOUNT TO TAKE CARE OF THE DELIVERY BUT DID NOT HAVE ANY MEDICAL INSURANCE AT THAT TIME. THEIR FINANCIAL PLANNING HAD, OF COURSE, NOT INCLUDED THE UNEXPECTED NEWS THAT MR. [redacted] WOULD ONLY HAVE SIX MONTHS TO LIVE. MR. [redacted] WAS ADMITTED MONTHLY FOR CHEMOTHERAPY AND ORTHOVOLTAGE RADIATION AND EXPIRED ON SEPTEMBER 9, 1985, FIVE MONTHS AFTER THE INITIAL ER VISIT.

MRS. [redacted] APPLIED FOR MEDICAID BUT WAS DENIED TO EXCESS RESOURCES. THESE EXCESS RESOURCES CONSISTED OF A TRUCK, CAMPER, BOAT AND TRAILER, AND $4500 IN THE BANK. WITH NO MONEY COMING IN, MRS. [redacted] HAD TO SELL EVERYTHING SHE COULD TO SUPPORT HERSELF AND HER NEWBORN BABY. SHE PAID $1000.00 ON THE FIRST INPATIENT STAY. MRS. [redacted] REAPPLIED FOR FOR MEDICAID WHICH APPROVED MR. [redacted]S LAST TWO INPATIENT STAYS. MEDICAID HAS PAID THEIR MAXIMUM BENEFITS ON THESE TWO HOSPITALIZATIONS

NOW, WITH MR. [redacted] DECEASED, MRS. [redacted] ONLY INCOME IS FROM SOCIAL SECURITY BENEFITS OF $646.00 PER MONTH. THIS GOES TO MEET THE ROUTINE LIVING EXPENSES FOR HERSELF AND HER BABY. MRS. [redacted] IS NOT WORKING AT THIS TIME AS SHE IS ATTENDING SCHOOL SO THAT SHE CAN RECEIVE A TEACHING CERTIFICATE TO BETTER SUPPORT THE TWO OF THEM. THE ONLY RESOURCE LEFT IS THEIR HOME.

PATIENT NUMBER	DATES OF SERVICE	ORIGINAL BALANCE	CURRENT BALANCE
466422-3	4/17 - 5/13/85	$ 15,066.34	$ 14,066.34
470861-6	5/21 - 5/25/85	$ 4,918.44	$ 4,918.44
472864-8	6/18 - 7/03/85	$ 7,467.32	$ 7,467.32
479564-7	7/16 - 7/20/85	$ 5,201.68	$ 2,690.81
482318-3	8/13 - 9/09/85	$ 23,922.98	$ 17,029.86

JDO

7/7/86

M E M O R A N D U M JULY 24, 1986

TO..... ELDON DINGLER
FROM..... VOL ROWLETT
SUBJECT.. CHARITY RECOMMENDATION

ACCOUNT # [redacted] PATIENT - [redacted] ADMITTED 7-8-86 AND DISCHARGED 7-16-86; ADMITTING PHYSICIAN WAS DR. GARY P. NUNN.
Amount of Bill is $5003.70

DR. NUNN CALLED ME BEFORE HE ADMITTED THIS PATIENT. HE HAS SEEING HER AT THE EAST LITTLE ROCK CLINIC. DR. NUNN STATED THAT THE PATIENT WAS IN NEED OF HOSPITAL CARE BUT HAD NO MONEY, INSURANCE OR OTHER MEANS OF PAYING FOR THE CARE THAT SHE NEEDED. SHE HAS APPLIED FOR MEDICAID. THE FINANCIAL INFORMATION SHEET THAT IS IN THE FOLDER WOULD SEEM TO BEAR OUT WHAT HE TOLD ME ABOUT THE PATIENT

I RECOMMEND THAT, PENDING THE OUTCOME OF HER APPLICATION, THAT A CHARITY WRITE OFF OF THE ACCOUNT BE APPROVED. SHOULD SHE BE AWARDED MEDICAID, THEN WE OF COURSE WILL BILL MEDICAID.

7/28/92

97

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM
JULY 24, 1986

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

RE: CHARITY APPLICATION: [redacted]
ACCOUNT INFORMATION: SEE INDIVIDUAL LISTING
SVI BALANCE AFTER INS & MCD: $ 4,015.09

MS. [redacted] WAS A 46 YEAR OLD DIVORCEE WHO WAS AT SVI NUMEROUS TIMES FROM 1980 UNTIL HER EXPIRATION ON MARCH 28, 1986 WITH A DIAGNOSIS OF CANCER.

MS. [redacted] MADE APPLICATION BEFORE SHE EXPIRED STATING THAT SHE WAS NOT ABLE TO WORK FULL TIME AT HER FREE LANCE FLORIST JOB DUE TO HER FREQUENT HOSPITALIZATIONS.

MS. [redacted] WAS COVERED BY BLUE CROSS/BLUE SHIELD WHICH HAS PAID ON ALL OF HER ACCOUNTS. SHE WAS APPROVED FOR MEDICAID IN FEBRUARY, 1986 WHICH PAID ON HER LAST THREE INPATIENT STAYS.

MS. [redacted] HAD NO ESTATE NOR OTHER FINANCIAL RESOURSES EXCEPT FOR A HOUSE WHICH IS MORTGAGED BEYOND ITS VALUE AND A 1975 AUTO.
MS. [redacted] HAD TWO SMALL INSURANCE POLICIES WHICH TOTALLED $7000. HER [redacted] USED THIS FOR BURIAL AND FUNERAL EXPENSES.

MS. [redacted] ALSO HAS TEN ACCOUNTS AT ISF WITH A COMBINED BALANCE OF $4,713.44.

PLEASE CONSIDER THIS $4,015.09 FOR CHARITY.

ACCOUNT #	CURRENT BALANCE	ORIGINAL CHARGES
498184	$ 312.90	$ 1,603.30
502553	$ 530.32	$ 2,273.16
503241	$ 415.32	$ 2,076.58
504308	$ 1,723.35	$ 4,235.88
508418	$ 101.60	$ 508.00
514253	$ 480.18	$ 2,330.27
515048	$ 67.74	$ 338.69
515664	$ 383.68	$ 7,654.54
TOTAL	$ 4,015.09	$21,020.42

7-24-86
Mr. Dingler:
I recommend the
this $4,015.09 be
written off to
Charity
Ed Overton

7/28/86

St. Vincent Infirmary
TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM

6-14-86
Mr Reynolds
Obtaining charity is the most practical handling of these two accts - I think

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: JUNE 19, 1986

RE: CHARITY APPLICATION: [redacted]
ACCOUNT NUMBER: [redacted]
DATE OF SERVICE: 09/10-24/84 10/16/84
TOTAL CHARGES OF ACCOUNTS: $14,257.59 $ 46.00

MR. [redacted] IS A 61 YEAR OLD MAN WHO WAS AN INPATIENT AT SVI FOR 14 DAYS IN SEPTEMBER, 1984 FOR CORONARY BYPASS SURGERY. HE WAS ALSO AN INPATIENT ON OCTOBER 16, 1984.

MR. [redacted] WAS A SELF-EMPLOYED CONTRACTOR AND HAD NO MEDICAL INSURANCE. HE REPORTED THAT HE HAD LITTLE INCOME IN 1984 AND STATED HE HAD A $10,894 LOSS DURING THE 12 MONTH PERIOD PRIOR TO SURGERY.

MR. [redacted] APPLIED FOR MEDICAID BUT WAS DENIED DUE TO EXCESS RESOURCES. MR. FLEMING SPOKE WITH MR. [redacted] DAUGHTER, [redacted] BY TELEPHONE IN MARCH, 1985. [redacted] STATED THE EXCESS RESOURCES WERE REFERRING TO FARM EQUIPMENT WHICH MR. [redacted] WAS GOING TO LOSE BECAUSE OF NON-PAYMENT.

THE [redacted] ARE LIVING ON MRS. [redacted] SOCIAL SECURITY BENEFITS OF $487.00 MONTHLY. MR. [redacted] HAS APPLIED FOR DISABILITY ALSO BUT HAD NOT BEEN APPROVED AS OF MARCH, 1985. THE [redacted] HAVE NO AVAILABLE RESOURCES TO APPLY TO THEIR MEDICAL EXPENSES. THEIR FIXED INCOME WILL ONLY MEET THEIR ROUTINE LIVING EXPENSES.

PLEASE CONSIDER THESE TWO ACCOUNTS FOR WRITE OFF.

JDO

OK BTK 7/3/86

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM

6-20-86
Mr. Reynolds -
I feel that the
Deficiency should
be handled as a
"charity" I/O -
VB Rowlett

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: JUNE 19, 1986

RE: PATIENT: [redacted]
PATIENT NUMBER: [redacted]
DATE OF SERVICE: 08/09 - 14/85
BALANCE AT DISCHARGE: $2072.33
BALANCE AFTER MEDICAID: $ 339.85

MRS. [redacted] WAS HERE FOR FIVE DAYS IN AUGUST, 1985 WITH A DIAGNOSIS OF INFECTION TO THE RIGHT LEG.

MRS. [redacted] HAS A VERY LIMITED INCOME AS A DOMESTIC WORKER AND IS ELIGIBLE FOR MEDICAID. MEDICAID WAS BILLED AND HAS PAID FOR FOUR DAYS OF THIS HOSPITALIZATION LEAVING THE $339.85 UNPAID.

WHEN MRS. [redacted] IS ABLE TO WORK, SHE MAKES $600.00 PER MONTH. THIS BARELY MEETS THE ROUTINE LIVING EXPENSES FOR HER AND HER FOUR DEPENDENTS.

MRS. [redacted] HAS NO OTHER FINANCIAL RESOURCES TO APPLY TOWARDS THIS ACCOUNT BALANCE.

7/1/86

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM

6-24-86
Mr. Reynolds
I recommend that
this be written
off to charity.
Ed Rowlett

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: JUNE 23, 1986

RE: PATIENT: [redacted]
PATIENT NUMBER: [redacted]

DATE OF SERVICE:	12/85	1/86	4/86
BALANCE AT DISCHARGE:	$4458.61	$28,555.10	$2900.56
BALANCE AFTER MEDICAID:	$1813.73	$16,217.10	$ 319.17

MS. [redacted] IS A 59 YEAR OLD WOMAN WHO HAS BEEN AT SVI FOR THREE INPATIENT STAYS WITH A DIAGNOSIS OF LEUKEMIA.

MS. [redacted] WAS HERE FROM DECEMBER 20, 1985 TO JANUARY 7, 1986 (18 DAYS); FROM JANUARY 29 TO MARCH 10, 1986 (40 DAYS); AND FROM APRIL 16 TO 24, 1986 (8 DAYS).

BECAUSE MS. [redacted] HAS NO INCOME, SHE IS ELIGIBLE FOR MEDICAID WHICH HAS BEEN BILLED AND HAS PAID THEIR MAXIMUM BENEFITS ON ALL THREE ACCOUNTS.

MS. [redacted] LIVES AT [redacted] NURSING HOME AND DOES NOT HAVE THE RESOURCES TO PAY THIS $18,350.00 BALANCE.

JDO

OP 7/1/86
BP

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM

6-24-86
Mr Reynolds
I suggest that this debt be written off to charity by
Ed Rowlett

TO: VOL B. ROWLETT

FROM: JOYCE OVERTON

DATE: JUNE 23, 1986

RE: CHARITY APPLICATION: [redacted]
PATIENT NUMBER: [redacted]
DATE OF SERVICE: DECEMBER 22 - 24, 1986
BALANCE AT DISCHARGE: $7709.21
BALANCE TO CONSIDER FOR CHARITY: $7609.21

MR. [redacted] IS 51-YEARS OLD AND WAS HERE FOR TWO DAYS FOLLOWING LITHOTRIPSY PROCEDURE.

MR. [redacted] HAS NO MEDICAL INSURANCE AND WAS DENIED BY MEDICAID DUE TO HIS NOT BEING PERMANENTLY DISABLED.

THE [redacted] HAVE LIMITED INCOME FROM MR. [redacted]S PENSION AND FROM A SMALL FIX-IT SHOP (AT THIS TIME THEY ARE NOT DOING MUCH BUSINESS DUE TO MR. [redacted] HEALTH). THEIR LIVING EXPENSES EXCEED THEIR INCOME AND THEY DEPEND ON FOOD STAMPS TO HELP.

THE [redacted] HAVE NO RESOURCES TO APPLY TOWARDS THIS ACCOUNT; BOTH THEIR TRUCK AND THEIR HOME ARE MORTGAGED. MRS. [redacted] PAID $100.00 AT DISCHARGE WHICH BRINGS THE ACCOUNT TO ITS CURRENT BALANCE OF $7609.21.

ACCORDING TO MRS. [redacted], THEY ARE JUST BARELY MAKING IT NOW. I DO NOT FEEL THEY WILL SOON HAVE THE FINANCIAL ABILITY TO PAY AN ACCOUNT OF THIS SIZE.

JDO

OP
PAT 7/1/86

MEMORANDUM
JUNE 27, 1986

TO: ELDON DINGLER
FROM: VOL ROWLETT
SUBJECT: CHARITY CONSIDERATION - -[redacted]. $925.50.

THIS ACCOUNT WAS ORIGINALLY $4,727.50. COMMERCIAL INSURANCE HAS PAID $3,702.0
AND THE PATIENT HAS PAID $100.00. PATIENT'S HUSBAND IS DISABLED AND DRAWS $12
A MONTH FROM SOCIAL SECURITY. PATIENT IS UNABLE TO WORK DUE TO ASTHMATIC CON
DITION. THEY HAVE RECENTLY HAD TO SELL A PART OF THEIR CHICKEN FARM - RECEIV
15,000. WHICH THEY HAD TO PUT DOWN ON HOUSE THEY NOW LIVE IN. THE BUYER OF TH
CHICKEN FARM "HOPES" TO BE ABLE TO PAY THEM 1,400.00 EVERY TWO MONTHS BEGINNIN
IN AUGUST. BUT THAT DEPENDS ON THE CHICKEN MARKET. MR & MRS [redacted] ARE NOT ABL
TO MAKE PAYMENTS ON THEIR OWN PLACE NOW AND WILL NOT BE ABLE TO UNTIL THE BUYE
OF THE CHICKEN FARM BEGINS HIS PAYMENTS. PATIENT HAS APPLIED FOR MEDICAID AND
BEEN DENIED DUE TO EXCESS PROPERTY. I TALKED TO MRS. [redacted] THIS AFTERNOON AN
REALLY DON'T BELIEVE THAT THEY HAVE ANY RESOURCES TO MAKE ANY PAYMENTS NOW ON
THIS BILL AND IT IS DOUBTFUL THEY WILL BE ABLE TO IN AUGUST.

I RECOMMEND THAT THIS BALANCE ($925.00) BE WRITTEN OFF TO CHARITY.

7/1/86

St. Vincent Infirmary
TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205-5499
TELEPHONE (501) 661-3000

MEMORANDUM

Mr Ziegler: I suggest A
charity W/O
Thanks!!
R

TO: J. GEORGE FLEMING

FROM: JOYCE OVERTON

DATE: APRIL 22, 1986

RE: CHARITY APPLICATION: [redacted]
PATIENT NUMBER: [redacted]
DATE OF SERVICE: SEPTEMBER 5-8, 1984
ORIGINAL BALANCE OF ACCOUNT: $ 4,662.46
BALANCE AFTER MEDICAID: $ 2,168.02

MR. [redacted] IS 36 YEARS OLD AND DISABLED. HE WAS A PATIENT AT SVI TWICE IN 1984 DUE TO COMPLICATIONS WITH HIS EMPHYSEMA. MRS. [redacted] IS ALSO DISABLED DUE TO BACK PROBLEMS.

THE [redacted] HAVE FOUR CHILDREN AND RECEIVE $325.00 MONTHLY IN SSI BENEFITS FOR THE CHILDREN. MR. [redacted] RECEIVES $282.00 IN SSI PAYMENTS MAKING A TOTAL INCOME OF $607.00. THE FAMILY ALSO RECEIVES FOOD STAMPS.

MR. [redacted] HAS BEEN DETERMINED DISABLED AND THEREFORE ELIGIBLE FOR MEDICAID: MEDICAID HAS PAID THEIR BENEFIT LIMIT ON BOTH ACCOUNTS. THE JULY, 1984 ACCOUNT WAS TURNED TO ISF BEFORE ST. VINCENT RECEIVED THE APPLICATION FOR CHARITY. NO COLLECTION PROCESSES HAVE BEEN INITIATED, HOWEVER, AS ISF IS AWAITING THE DECISION ON THE APPLICATION FROM ST. VINCENT.

THE [redacted] HAVE NO FINANCIAL RESERVES TO APPLY TOWARDS THIS ACCOUNT. THEIR INCOME OF $607.00 ONLY MAKES THEIR HOUSE PAYMENTS AND PAYS THEIR UTILITIES.

MR. [redacted] IS PERMANENTLY DISABLED AND I DO NOT FEEL HE WILL EVER HAVE THE RESOURCES TO PAY THIS BALANCE.

JDO

R 6/19/86

St. Vincent Infirmary

TWO ST. VINCENT CIRCLE
LITTLE ROCK, ARKANSAS 72205 5499
TELEPHONE (501) 661 3000

MEMORANDUM

Mr. Overton
I recommend charity
pay off these accts.
[illegible]

TO: GEORGE FLEMING

FROM: JOYCE OVERTON

DATE: APRIL 25, 1986

RE: CHARITY APPLICATION: [redacted]

	PATIENT NUMBERS:	[redacted]	[redacted]
	DATE OF SERVICE:	10/84	11/84
	ORIGINAL ACCOUNT TOTAL:	$ 4,145.92	$ 5,869.20
	BALANCE AFTER MEDICAID:	$ 1,105.47	$ 770.93

MRS. [redacted] IS A 62 YEAR OLD WOMAN WHO WAS AN INPATIENT AT SVI THREE TIMES IN 1984 WITH A DIAGNOSIS OF CONGESTIVE HEART FAILURE COMPOUNDED BY DIABETES.

MRS. [redacted] AND HER HUSBAND LIVE WITH THEIR (DISABLED) DAUGHTER IN [redacted], ARKANSAS. THE THREE OF THEM HAVE A COMBINED MONTHLY INCOME OF ONLY $549.00 ($202.00 IN SOCIAL SECURITY FOR MR. [redacted], $102.00 SSI FOR MRS. [redacted], AND $245.00 SSI FOR THE DAUGHTER).

THE [redacted] HAD NO COMMERCIAL INSURANCE. MRS. [redacted] WAS COVERED BY MEDICAID WHICH HAS PAID MAXIMUM BENEFITS ON THESE ACCOUNTS LEAVING A TOTAL DUE OF $1,876.40.

THE [redacted] INCOME BARELY MEETS ROUTINE LIVING EXPENSES. THEY OWE OTHER MEDICAL BILLS ALSO, ON WHICH THEY ARE UNABLE TO PAY. THEY HAVE NO FINANCIAL RESOURCES AVAILABLE TO APPLY TOWARDS THESE ACCOUNTS. I RECOMMEND CONSIDERING THESE BALANCES FOR CHARITY WRITE OFF.

OK per 6/18/86

Senator PRYOR. Thank you very much, Dr. Busfield. Our last witness and certainly not the least, we just appreciate you being here, and we're looking forward to your statement. Right after your statement is completed, I'm going to call on our Senator Bumpers, who has just arrived. If you would make your statement, then I'm going to ask Senator Bumpers to come forward. If fact, Dale, why don't you come up here now. This gentleman is not Arkansas' senior citizen. He is, however, Arkansas' senior Senator, and he never lets me forget that. Go right ahead.

STATEMENT OF DIXIE DUGAN, NORTH LITTLE ROCK, AR, EXECUTIVE DIRECTOR, CENTRAL ARKANSAS AREA AGENCY ON AGING

Ms. DUGAN. Thank you, Senator Pryor and Senator Bumpers. I will try to be quick. I did appear before the Private Public Sector Advisory Committee on Catastrophic Illness earlier this month, and I would like for you to please enter that statement that I made to them as a part of this initial record. To prepare that statement I did call together some people in Arkansas who are older consumers: Mr. Lantrip, Mr. John Goodwin, Mr. Casey Johnson, and others. We worked on two particular areas: The definition of catastrophic illness and then the financing, because these are very important. The definition that we came up with is this: Catastrophic illness is an economic catastrophe associated with an illness regardless of age, type of disease, and length of illness. That's our definition.

Also on financing, it is our opinion that the least objectionable way is through general revenues in the national budget. We know that's difficult in this present time. In regard to the individual medical account, we would like to tell you that older consumers are very concerned that we are not going to have a very carefully planned and executed phasing period so that if we do decide that is the right way to go, we want you all in Congress to be very careful that we take our time and we do things in such a way that these people who are now paying for the system don't have to take care of two generations.

The last thing I want to tell you both is that I personally know a lot of older consumers, older constituents of yours in this State who are bitter because, just as you say, they thought they were covered by their insurance and Medicare and whatever and came up with an illness, and all of their resources were depleted and they were left impoverished, and so they worked all of their lives for that, and now they are bitter because they are broke and sick and they die poor, so you have a big problem, and we know you'll do it well for us. Thank you.

[The prepared statement of Ms. Dugan follows:]

CENTRAL ARKANSAS AREA AGENCY ON AGING, INC.

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DIXIE DUGAN
Executive Director

STATEMENT TO PRIVATE/PUBLIC SECTOR ADVISORY COMMITTEE
ON CATASTROPHIC ILLNESS

By Dixie Dugan

Thank you for this opportunity to comment on the important health related issue of catastrophic illness. At the outset let me say, I am pleased that catastrophic illness is a concern to policy-makers in this country. I must advise that I believe that a national policy on long-term care is far more needed. The costs of long-term care can be catastrophic for individuals as well as government.

With this in mind, I would define catastrophic illness just as Mr. James Balog has done, with one addition:

> Catastrophic illness is an economic catastrophe associated with an illness, regardless of age, type of disease, and length of illness.

It has been suggested that Individual Medical Accounts (IMA's) be used to finance catastrophic illnesses. If IMA's are a sound proposal for financing health care, why restrict their use to catastrophic illnesses? Would IMA's not be more effective in achieving basic reform in how this country pays for all health care?

In completing a study on health care for older Americans for the Federal Council on the Aging, I synthesized information on IMA's from representatives of a number of national organizations including the American Medical Association, the U. S. Chamber of Commerce and the American Association of Retired Persons. An excerpt from that report regarding the positive and negative aspects of IMA's are attached to this statement for your review. Please note, the pros far outweigh the cons.

706 W. 4th STREET, P.O. BOX 5988, NORTH LITTLE ROCK, ARKANSAS 72119 - (501) 372-5300
EQUAL OPPORTUNITY EMPLOYER

However, one big caution light flashes. If IMA's are to be successful there must be a carefully planned and executed phase-in period to assure that no one generation is required to pay into the present system to support current beneficiaries while paying into a separate system to insure their own future coverage.

In reviewing ways for this country to pay for catastrophic illnesses, an Arkansas Ad Hoc Committee of representatives from senior citizens groups including AARP concluded that the least objectionable way to do so is through general revenues appropriated in the national budget.

Again, thank you for having me here to tell you how important it is to the at-risk elderly for the Private/Public Sector Advisory Committee on Catastrophic Illness to carefully design your recommendations. The basic definition of catastrophic illness as well as how catastrophic illness will be paid for are key considerations for you.

Thank you.

- - - From HEALTH CARE FOR OLDER AMERICANS, a study for the Federal Council on Aging, by Dixie Dugan.

Individual Medical Accounts (IMA's)

An issue deserving further study is the possibility of establishing Individual Medical Accounts (IMA's) as a supplement to the Medicare program, according to the Advisory Council on Social Security.[35] Peter Ferrara, an attorney associated with the Heritage Foundation, has structured a proposal for fundamental reform of the Medicare program that would completely replace the existing system.[36] The plan, which calls for Health Bank Individual Retirement Accounts, would establish special tax free savings accounts similar to existing Individual Retirement Accounts (IRA's) for income security purposes. The major criticism of this concept is that it creates a two-tiered health care delivery system. The reverse response is that a two-tiered delivery system is acceptable if each system provides health care meeting basic standards of quality. Advocates for older consumers caution that the adoption of the individual medical account concept requires careful planning and a well executed transition from the existing system.

Option 3. Establish health bank account IMA's.

PRO'S	CON'S
Enables and encourages individuals to plan and provide for their own future health care needs.	Creates a two-class health care system.
Phases in over an extended period, possibly 30 years.	Discriminates against the poor who may be financially unable to establish an IMA.
Reduces the anxiety the aged have about the possibility of being confronted with medical expenditures beyond their means to pay for them.	Represents no immediate savings to government health care insurance programs.
Provides tax incentives for working Americans.	Could cause a reduction of federal tax revenues, possibly even adding to the national deficit.
Accrues to the aged person's estate on his or her death.	
Represents long term restructuring of the financing of health care for older Americans.	
Costs workers less over the long run.	

Option 3. Establish health bank account IMA's. (cont'd)

PRO'S	CON'S
Reduces the anticipated growth of government medical spending over the long run.	
Totally replaces the current Medicare system, representing broad reform of how health care of the aged is financed and delivered.	
Reduces payroll taxation for employers, employees, and the self employed.	
Requires no reduction in existing health care benefits and has the potential to produce additional benefits at reduced costs.	
Protects future medical security of today's young worker through the establishment of an improved and soundly based system.	
Provides market return to capital workers' contributions. (No such return is available under the current system).	

Option 3. Establish health bank account IMA's. (cont'd)

PRO'S

Allows for a wider scope for the operation of private market incentives as individuals would use their IMA income to purchase insurance and services from the private market (increases competition among health care providers).

Lessens the financial pressures on government to fund health care.

Provides financial incentives to consumers to conserve medical resources.

Encourages consumers to maintain healthy lifestyles and thereby minimize the costs of health care.

Encourages private savings which will boost the economy.

Sharply increases workers' control and choice over individual medical coverage.

Frees government resources to provide essential aid such as catastrophic coverage.

CON'S

Option 3. Establish health bank account IMA's. (cont'd)

PRO'S	CON'S
Expands the role of the private sector by enabling most workers to place funds in IMA's which would then be invested in private industry.	
Should even be within the financial means of minimum wage workers to establish IMA's.	
Protects the poor with means-tested supplements.	
Would boost national savings.	

Senator PRYOR. Thank you, Dixie, very much for that statement. Now I'm going to call on Senator Bumpers, and after Senator Bumpers' statement, we are going to allow the audience to ask any questions of this panel or to make a short statement for the hearing record. Senator Bumpers.

STATEMENT BY SENATOR DALE BUMPERS

Senator BUMPERS. Mr. Chairman, first let me express my profound thanks to you for holding this hearing on behalf of the Senate Special Committee on Aging and tell you that because of my schedule I had to do cartwheels to participate in today's hearing. I apologize for being a little bit late, and I ask your indulgence for allowing me to leave immediately after my testimony. I have to hurry off to Paragould for a couple of events tonight. I did change my schedule and did those cartwheels because this is an issue about which I feel strongly. Let me ask you now, Mr. Chairman, that my formal statement be entered in the record, and I'll just extemporize on that statement, with your permission.

My mail and my polls reflect that if you ask the people of this State what upsets them most, what angers them most, what concerns them most, they'll tell you it is health care costs. And if you analyze that, you'll find it is not just everyday, routine health care costs that frighten them, it is the fear that a catastrophic illness will wipe out their life savings. By the time they retire, many people have saved $20,000, $30,000, $40,000, $50,000. But their fear is that they are going to have a long-term illness which wipes out their lifetime savings and takes their home.

When I saw a poll indicating how concerned people are about health care costs a little over a year ago, I became vitally concerned with this issue of so-called catastrophic illness. Now, how you define catastrophic illness is anybody's guess. Normally the definition of a catastrophic illness is any illness which requires more than 5 percent of a person's annual income in excess of his medical coverage. Studies of the number of families that paid more than 5 percent of their annual income or 10 percent or even 20 percent have yielded staggering figures.

Now, we are here today just to address the topic of long-term care and catastrophic illness for the elderly. But I think it's important to note right here that a Congressional Budget Office study found that even if you exclude both the poor and the elderly you'll find a large number of families facing high medical bills. Congressional Budget Office studies show that every year 11 percent of the 53 million families in that category who are neither elderly nor poor suffered catastrophic illnesses and catastrophic costs. And now to go on to the issue of the elderly, 25 percent of the elderly's hospital and medical costs are being paid by them out of their own pockets.

Many people in this country think because they have Medicare or even because they have Medi-Gap that they are fully insured and that they will not suffer the adversities that I mentioned a moment ago. But right now the elderly in this country are, on the average, spending up to 25 percent of their income on medical expenses; 1985, last year, this country spent $425 billion, 10.9 percent

of our total gross national product, on health care costs, more than any nation on Earth. And while health care costs only went up 8.9 percent last year, a slower rate of increase than the acceleration of health care costs in past years, that was still three times higher than the inflation rate for the rest of the economy.

Now, an awful lot of elderly people don't even have Medi-Gap, and Medicare doesn't cover long-term care. We have about 250 nursing homes in this State, Mr. Chairman, and I bet less than 10 are qualified for Medicare, and the reason is because the inordinate amount of paperwork that Medicare requires of nursing homes, and the other is that Medicare pays for a limited number of days in a nursing home. That's one of the reasons over 45 percent of the total costs of nursing homes costs in this country are being paid by Medicaid. In order for one to qualify for Medicaid, they must impoverish themselves. They must spend their life savings to be eligible for Medicaid, and many of them are doing that. That requirement means by the time they go to a nursing home they have had to impoverish themselves.

About 22 percent of all people in this country over 85 are now in nursing homes. When you consider the fact that Medicare pays for very little of that, you can see how many people are depending on Medicaid to pay for their nursing home care.

Mr. Chairman, I don't have any solutions. The reason I know you are holding these hearings is so we can benefit from the expertise of these prestigious witnesses who know about health care costs, and who know what long-term care is. There are a number of bills floating around in Congress, and I've been trying to find one that I thought was the best to cosponsor. We must come to grips with this problem. The elderly people of this country are looking to government. They are looking legitimately to the government as a solver of this problem, and so I just have three or four suggestions that are only a small part of the list.

No. 1, we offer something like IRA's, to allow people to put money into an IRA to pay for long-term care and pay for catastrophic illnesses. No. 2, we should encourage private insurance companies to provide better coverage for the elderly's out-of-pocket costs and particularly for catastrophic illnesses. No. 3, we need a better Medi-Gap program. There's a Harvard study that says we ought to combine part A and part B of Medicare and then form a part C which would take care of both long-term care and the deficiency between the bills Medicare beneficiaries receive and what Medicare pays. They have suggested—and there is also a bill in Congress along this line—that we should charge premiums of $800 a year for the coverage that I just described, but not more than 25 percent of one person's income. Let me state that over again so that I won't be misunderstood. If you consider the difference between what Medicare pays and what the elderly are being charged for medical care, you are talking about a large share of cost of health care that the elderly pay. The elderly have to pay out of pocket for eyeglasses and a whole bunch of things that Medicare doesn't cover. A lot of elderly in this country are often forced to choose between food and health care, between energy cost and health care. And for the richest Nation on Earth to require those

who are most vulnerable in our society to make those kinds of choices is unforgivable and unacceptable.

The bill I have referred to suggests that Medicare beneficiaries would pay $800 a year and this would cover all their health care costs. The $800 a year would do two things: take care of that 25 percent you are now paying out of your pocket, that is, the difference between what Medicare pays and what you are paying; and take care of long-term care and catastrophic expenses. While $800 a year seems like a lot of money, to alleviate that fear of being wiped out, it might be acceptable.

Now, Mr. Chairman, as Earle Long used to say when he was Governor of Louisiana, "Them's my views, and if you don't like them, I'll change them." Senator Pryor, thank you very much for coming to our beloved State to address one of the most critical problems in the country. Not only is Senator Pryor active on the Committee on Aging, but he is also on the Finance Committee where all these things are ultimately resolved. David and I have this little arrangement. If somebody comes in and says, Oh, Senator, We need this and we need this new park or something else, he always says, you go see Senator Bumpers. We are so fortunate he's on the Appropriations Committee, and I know he can get that for you with no problem. So when people come to me about their taxes, I say, listen, we are so lucky to have Senator Pryor on the Finance Committee. He can handle that for you. You all know David's been interested in the problems of aging ever since he got into politics and even before, so I'm honored to be here with all of you today. I regret that I can't stay for the audience participation, which would be the most interesting part of this. Again, my thanks to you, Mr. Chairman, for holding these hearings.

[The prepared statement of Senator Bumpers follows:]

TESTIMONY OF SENATOR DALE BUMPERS

AT HEARING ON HEALTH CARE FOR OLDER AMERICANS

INSURING AGAINST CATASTROPHIC LOSS

Thursday, August 28
Pulaski Heights Presbyterian Church
Little Rock, Arkansas

I want to take this opportunity to thank Senator Pryor for inviting me to this hearing on catastrophic health care expenses. We cannot delay much longer dealing with this problem which many Americans list as their number one worry, and this hearing is an important beginning.

I get a lot of mail from working men and women whose life savings have been completely wiped out because of catastrophic health expenses. They wonder how they are going to put their children through college and meet other extraordinary expenses. And they fear future catastrophic expenses as well. They look to us, their elected representatives, for help. They view this as precisely the kind of problem that government should be providing solutions for. We must begin to grapple with this very serious problem, and we look to the witnesses here today to suggest some possible solutions.

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No American family is immune from catastrophic health care costs. A family which is fortunate enough to have good health insurance in effect subsidizes the catastrophic expenses of other families most years and is likely to be subsidized for its own catastrophic expenses in other years. A 1982 Congressional Budget Office Study focused on high-cost illness in the non-elderly, non-poor population -- about 53 million families. The authors of this study excluded the elderly and poor, two high risk groups, and still they found that a large number of American are at risk of catastrophic medical expense. The study found that 11 percent of all families exceeded catastrophic thresholds in one year; 20 percent reached that level at least once in a 2-year period; and fully one-fourth of all families exceeded the threshold at least once in a three-year period. Those are frightening statistics for families who are likely to have good health insurance coverage. And the risks of catastrophic medical expenses are much greater for the elderly and the poor.

This hearing focuses on the catastrophic losses of the elderly, and so I want to discuss that group. We know that the poorest of the elderly are spending 25% of their income on health care. Senior citizens who are struggling to buy food and shelter with fixed incomes cannot afford to spend one-fourth of their Social Security checks on prescription drugs, eyeglasses, physician visits, and other health care. The elderly must sometimes make the

choice between food and medical care or heat and medical care. Citizens of the richest country on earth should not be forced to make that choice.

A recent study by the National Center for Health Services Research -- which looked at all segments of the population -- found that one in five American families faces catastrophic medical expenses each year. The study defined catastrophic costs as out-of-pocket expenses exceeding 5%, 10%, and 20% of a family's gross income. Out-of-pocket expenses are costs beyond those covered by private or public health insurance or by Medicaid or other government programs. One-third of the sixteen million families with expenses equaling 5 percent of their income were headed by persons 65 and over. And elderly families comprised just as large a proportion of the groups with health expenditures of 10 percent and 20 percent of income. 9.6% of families had health care expenditures of 10 percent of family income and 4.3% of families had expenses equal to 20 percent of family income. One-third of the families in each of those groups were elderly.

Medicare is one of the greatest legacies of the 1960s, and it has provided senior citizens the best health care they have ever had. Medicare has made the sophisticated technology of American medicine available to the elderly, but it has come at a very high price. One estimate indicates that the elderly are spending more on health care in 1986 than they were in 1966, just after Medicare was enacted.

It is estimated that in 1986 the elderly will pay an estimated 16% of their income on health care. That is about $1850 per capita. The elderly were spending about 15% of their income on health care in 1966.

Why have we lost control of out-of-pocket health care costs? There are many reasons. One, the rise in health care costs has far outstripped the rise in elderly incomes in recent years. The figures on 1985 health care costs have just been released. In 1985, the nation spent $425 billion on health care, or about 10.7% of the gross national product. That is more than any other industrialized nation spends on health care. Health care spending rose 8.9% above the 1984 level, the lowest annual rate of increase in two decades. We have congratulated ourselves for our success in moderating medical inflation and overall health care expenditures, but a 8.9% inflation rate is still too high. If we adjusted that figure for the very low general inflation rate, we would find that health care costs themselves are actually increasing at historic rates. And the elderly feel the squeeze of health care inflation every single day.

Second, Medicare covers only about one half of the health care expenses of the elderly. The remainder is paid for out-of-pocket, by Medicaid, by private insurance, or by other government funds. Medicare does not pay for prescription drugs, for eyeglasses, or for many addiitonal outpatient services. The change in the system of paying

hospitals for caring for Medicare beneficiaries has resulted in some services being shifted to an outpatient basis, where Medicare coverage is often spotty.

Most -- more than two-thirds of Medicare beneficiaries -- purchase supplemental insurance policies. And a number of Medicare beneficiaries qualify for Medicaid. Unfortunately, a significant minority of the elderly are without good medigap coverage or don't qualify for Medicaid, and they face especially high out-of-pocket costs.

Third, Medicare does not cover long term care. A Gallup Poll conducted for the American Association of Retired Persons in 1984 found that 79 percent of respondents believed that Medic re pays the bill for long term care in a nursing home. Yet Medicare only pays for a maximum of 100 days in a skilled Nursing Home in a benefit period.

Who does pay for nursing home care, which can run as high as $20,000 to $30,000 annually? Medicaid is the main source of public funds for nursing homes. About half of nursing home care is paid for by Medicaid, about 45 percent from private sources, and about 2 percent from private insurance. Many of the elderly whose nursing home care is paid for by Medicaid got that coverage only after they "spent down" to the poverty level to become eligible for Medicaid. People must bankrupt themselves if they are to receive Medicaid coverage for long term care.

Finally, the need for long term care is by far the greatest amoung those 85 and older, and that population group is growing rapidly. In 1984, according to the National

A blue ribbon commission at Harvard University offered a proposal for reform of the Medicare program earlier this year after two years of research, debate, and discussion. This committee recommended that Medicare A and B be combined into a single mandatory program and that the elderly continue to pay about 25% of total program costs through premiums. The committee recommended that benefitiaries' financial liability be made more predictable and that there be a reasonable limit on the total annual amount all beneficiaries pay for coinsurance and deductibles. The commission also recommended that Medicare be expended to include coverage for long term care.

And there are several legislative proposals that address catastrophic health care expenses and the financing of long term care. In the Senate a measure is pending which would provide a deduction from gross income for individual taxpayers who maintain a household which includes a dependent of the taxpayer who suffers from Alzheimer's desease. Thre are also bills pending that would expend Medicare coverage; one would replace Medicare A and B with an optional Medicare Part C program that would cover all medical costs, including long term care. The cost to the government for this program would be no more than current Medicare costs and the cost to the individual for the Part C program would be about $800 a year, or no more than 25% of gross income. Another measure would limit out-of-pocket expenses for beneficiaries and would finance the improved coverage with

increased Part A and Part B premiums. This plan would build on existing Medigap policies. There are literally dozens of other proposals, some limited in scope and some comprehensive.

There are benefits to and problems with all of the proposals that have been introduced and debated. Some have been criticized because they do not offer enough financial protection to the elderly and others have been criticized for changing the systems for paying health care providers too dramatically. Another persistent criticism of many of the reform proposals is that they would increase the cost to the federal government, a concern which cannot be dismissed in light of huge budget deficits.

Mr. Chairman, as I mentioned, I have come to this hearing to state in the strongest possible terms my belief that it is time to find solutions to the knotty problem of catastrophic health costs. It won't be easy in these days of $200 billion a year federal budget deficits and with many of our small businesses and industries barely holding on by their thumbs. But here in the greatest and wealthiest nation on earth, where the finest medical care is available, we cannot allow the cost of catastrophic illness to devastate our citizens. With the incredible ingenuity and good will of our people, we can and will solve this problem, and I will do everything within my power to see that we do.

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BILL TO
FRANCES SMITH
16 BLUE RIDGE CIRCLE
LITTLE ROCK AR 72207

QUESTIONS REGARDING BILL CALL 370-7211

PATIENT

MO	DAY	YEAR		ADMISSION NO	DATE ADMITTED	DATE DISCHARGED
8	09	86	FRANCES SMITH	70717	7 02 86	8 09 86

MO	DAY	YEAR	SERVICE RENDERED	CHARGES	CREDITS	BALANCE
7	02	86	DAILY CARE	287.00		
7	02	86	LABORATORY	219.00		
7	02	86	CENTRAL SUPPLY	11.40		
7	02	86	RESPIRATORY THERAPY	79.00		
7	02	86	E.C.G.	86.50		
7	03	86	DAILY CARE	287.00		
7	03	86	OCCUPATIONAL THERAPY	82.00		
7	03	86	PHYSICAL THERAPY	59.50		
7	03	86	SPEECH PATH AUDIOLOGY	45.00		
7	03	86	PHARMACY	6.10		
7	03	86	LABORATORY	41.50		
7	03	86	CENTRAL SUPPLY	4.48		
7	04	86	DAILY CARE	287.00		
7	04	86	PHYSICAL THERAPY	37.50		
7	04	86	PHARMACY	6.75		
7	04	86	CENTRAL SUPPLY	3.10		
7	05	86	DAILY CARE	287.00		
7	05	86	CENTRAL SUPPLY	4.49		
7	05	86	E.C.G.	58.00	9.00	
7	06	86	DAILY CARE	287.00		
7	06	86	PHARMACY	11.30		
7	07	86	DAILY CARE	287.00		
7	07	86	OCCUPATIONAL THERAPY	34.50		
7	07	86	PHYSICAL THERAPY	93.50		
7	07	86	SPEECH PATH AUDIOLOGY	53.00		
7	07	86	PHARMACY	22.45	1.10	
7	07	86	LABORATORY	96.25		
7	07	86	CENTRAL SUPPLY		4.48	
7	07	96	X-RAY	82.00		
7	08	86	DAILY CARE	287.00		
7	08	86	OCCUPATIONAL THERAPY	49.00		

THIS COPY FOR YOUR INFORMATION ONLY.
A MEDICARE [illegible] BEEN FILLED.
RECEIPT OF [illegible] PAYMENT. STATEMENT
BALANCE IF ANY WILL BE MAILED.

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MO.	DAY	YEAR		ADMISSION NO.	DATE ADMITTED	DATE DISCHARGED
			FRANCES SMITH	70717 86		

MO.	DAY	YEAR	SERVICE RENDERED	CHARGES	CREDITS	BALANCE
7	08	86	PHYSICAL THERAPY	37.50		
7	08	86	SPEECH PATH AUDIOLOGY	57.00		
7	08	86	PHARMACY	5.65		
7	08	86	CENTRAL SUPPLY	6.00		
7	09	86	DAILY CARE	287.00		
7	09	86	OCCUPATIONAL THERAPY	69.00		
7	09	86	PHYSICAL THERAPY	93.50		
7	09	86	SPEECH PATH AUDIOLOGY	53.00		
7	09	86	PHARMACY	5.65	1.10	
7	10	86	DAILY CARE	287.00		
7	10	86	OCCUPATIONAL THERAPY	70.50		
7	10	86	PHYSICAL THERAPY	37.50		
7	10	86	PHARMACY	460.50	216.40	
7	10	86	LABORATORY	162.50		
7	10	86	CENTRAL SUPPLY	90.73		
7	10	86	X-RAY	242.00		
7	11	86	DAILY CARE	287.00		
7	11	86	OCCUPATIONAL THERAPY	10.62		
7	11	86	PHYSICAL THERAPY	54.00		
7	11	86	SPEECH PATH AUDIOLOGY	45.00		
7	11	86	PHARMACY	7.10		
7	11	86	CENTRAL SUPPLY	8.30		
7	11	86	I. V. SOLUTIONS	10.04		
7	12	86	DAILY CARE	287.00		
7	12	86	PHARMACY	28.00		
7	12	86	CENTRAL SUPPLY	16.50		
7	13	86	DAILY CARE	287.00		
7	13	86	PHARMACY	81.15		
7	13	86	CENTRAL SUPPLY	27.68		
7	14	86	DAILY CARE	287.00		
7	14	86	OCCUPATIONAL THERAPY	24.50		
7	14	86	PHYSICAL THERAPY	27.00		

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MO	DAY	YEAR	PATIENT	ADMISSION NO	DATE ADMITTED	DATE DISCHARGED
			FRANCES SMITH	70717	86	

DATE MO	DAY	YEAR	SERVICE RENDERED	CHARGES	CREDITS	BALANCE
7	14	86	SPEECH PATH AUDIOLOGY	23.50		
7	14	86	PHARMACY	28.70	1.40	
7	14	86	LABORATORY	53.50		
7	14	86	CENTRAL SUPPLY	.85	10.85	
7	15	86	DAILY CARE	287.00		
7	15	86	OCCUPATIONAL THERAPY	34.50		
7	15	86	PHYSICAL THERAPY	37.50		
7	15	86	SPEECH PATH AUDIOLOGY	45.00		
7	15	86	PHARMACY	12.20	135.25	
7	15	86	LABORATORY	32.50	16.25	
7	16	86	DAILY CARE	287.00		
7	16	86	OCCUPATIONAL THERAPY	69.00		
7	16	86	PHYSICAL THERAPY	75.00		
7	16	86	SPEECH PATH AUDIOLOGY	45.00		
7	16	86	PHARMACY	6.10	.70	
7	16	86	CENTRAL SUPPLY	3.10		
7	16	86	E.C.G.	37.50		
7	17	86	DAILY CARE	287.00		
7	17	86	OCCUPATIONAL THERAPY	102.50		
7	17	86	PHYSICAL THERAPY	27.00		
7	17	86	SPEECH PATH AUDIOLOGY	45.00		
7	17	86	PHARMACY	6.10		
7	17	86	LABORATORY	16.25		
7	18	86	DAILY CARE	287.00		
7	18	86	OCCUPATIONAL THERAPY	34.50		
7	18	86	PHYSICAL THERAPY	64.50		
7	18	86	PHARMACY	6.60		
7	18	86	LABORATORY	16.25		
7	18	86	CENTRAL SUPPLY	3.68		
7	19	86	DAILY CARE	287.00		
7	19	86	PHARMACY	6.60		
7	19	86	LABORATORY	16.25		

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MO	DAY	YEAR	PATIENT	ADMISSION NO	DATE ADMITTED	DATE DISCHARGED
			FRANCES SMITH	70717 86		

MO	DAY	YEAR	SERVICE RENDERED	CHARGES	CREDITS	BALANCE
7	19	86	RESPIRATORY THERAPY	35.00		
7	20	86	DAILY CARE	287.00		
7	20	86	LABORATORY	16.25		
7	20	86	RESPIRATORY THERAPY	9.50		
7	21	86	DAILY CARE	287.00		
7	21	86	OCCUPATIONAL THERAPY	102.50		
7	21	86	PHYSICAL THERAPY	27.00		
7	21	86	SPEECH PATH AUDIOLOGY	45.00		
7	21	86	PHARMACY	14.20	1.00	
7	21	86	LABORATORY	86.00	16.25	
7	21	86	CENTRAL SUPPLY	4.53		
7	21	86	RESPIRATORY THERAPY	9.50		
7	22	86	DAILY CARE	287.00		
7	22	86	PHARMACY	10.75		
7	22	86	LABORATORY	158.00		
7	22	86	CENTRAL SUPPLY	17.00		
7	22	86	RESPIRATORY THERAPY	8.50		
7	22	86	E.C.G.	37.50		
7	23	86	DAILY CARE	287.00		
7	23	86	PHARMACY	14.20	2.85	
7	23	86	LABORATORY	165.50		
7	23	86	CENTRAL SUPPLY	20.03	17.00	
7	23	86	RESPIRATORY THERAPY	8.50		
7	23	86	E.C.G.	37.50		
7	24	86	DAILY CARE	287.00		
7	24	86	LABORATORY	41.50		
7	24	86	CENTRAL SUPPLY	13.88		
7	24	86	RESPIRATORY THERAPY	8.50		
7	25	86	DAILY CARE	287.00		
7	25	86	OCCUPATIONAL THERAPY	24.50		
7	25	86	SPEECH PATH AUDIOLOGY	45.00		
7	25	86	PHARMACY	17.00		

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			FRANCES SMITH	70717 86		

MO.	DAY	YEAR	SERVICE RENDERED	CHARGES	CREDITS	BALANCE
7	25	86	RESPIRATORY THERAPY	8.50		
7	26	86	DAILY CARE	287.00		
7	26	86	SPEECH PATH AUDIOLOGY	23.50		
7	26	86	RESPIRATORY THERAPY	8.50		
7	27	86	DAILY CARE	287.00		
7	27	86	PHARMACY	13.65		
7	27	86	RESPIRATORY THERAPY	8.50		
7	28	86	DAILY CARE	287.00		
7	28	86	OCCUPATIONAL THERAPY	101.50		
7	28	86	PHYSICAL THERAPY	71.00		
7	28	86	SPEECH PATH AUDIOLOGY	78.50		
7	28	86	PHARMACY	26.20	7.05	
7	28	86	LABORATORY	32.50		
7	28	86	CENTRAL SUPPLY	3.10		
7	28	86	RESPIRATORY THERAPY	8.50		
7	29	86	DAILY CARE	287.00		
7	29	86	OCCUPATIONAL THERAPY	140.00		
7	29	86	PHYSICAL THERAPY	75.00		
7	29	86	SPEECH PATH AUDIOLOGY	45.00		
7	29	86	PHARMACY	11.80		
7	29	86	LABORATORY	91.25		
7	29	86	CENTRAL SUPPLY	4.50		
7	29	86	RESPIRATORY THERAPY	8.50		
7	30	86	DAILY CARE	287.00		
7	30	86	OCCUPATIONAL THERAPY	50.00		
7	30	86	PHYSICAL THERAPY	37.50		
7	30	86	SPEECH PATH AUDIOLOGY	45.00		
7	30	86	PHARMACY	11.80	1.00	
7	30	86	RESPIRATORY THERAPY	8.50		
7	31	86	CREDIT		3,742.37	
7	31	86	DAILY CARE	287.00		
7	31	86	OCCUPATIONAL THERAPY	50.00		

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			FRANCES SMITH	70717 86		

MO	DAY	YEAR	SERVICE RENDERED	CHARGES	CREDITS	BALANCE
7	31	86	PHYSICAL THERAPY	75.00		
7	31	86	SPEECH PATH AUDIOLOGY	49.00		
7	31	86	PHARMACY	12.55		
7	31	86	RESPIRATORY THERAPY	8.50		
8	01	86	DAILY CARE	287.00		
8	01	86	OCCUPATIONAL THERAPY	68.00		
8	01	86	PHYSICAL THERAPY	64.50		
8	01	86	SPEECH PATH AUDIOLOGY	23.50		
8	01	86	PHARMACY	12.55	2.00	
8	01	86	LABORATORY	45.25		
8	01	86	CENTRAL SUPPLY	6.00		
8	01	86	RESPIRATORY THERAPY	8.50		
8	02	86	DAILY CARE	287.00		
8	02	86	LABORATORY	61.75		
8	02	86	RESPIRATORY THERAPY	47.50		
8	02	86	E.C.G.	37.50		
8	03	86	DAILY CARE	287.00		
8	03	86	PHARMACY	25.50		
8	03	86	CENTRAL SUPPLY	.95		
8	03	86	RESPIRATORY THERAPY	8.50		
8	04	86	DAILY CARE	287.00		
8	04	86	OCCUPATIONAL THERAPY	68.00		
8	04	86	PHYSICAL THERAPY	75.00		
8	04	86	SPEECH PATH AUDIOLOGY	45.00		
8	04	86	PHARMACY	12.75		
8	04	86	CENTRAL SUPPLY	19.48		
8	04	86	RESPIRATORY THERAPY	8.50		
8	05	86	DAILY CARE	287.00		
8	05	86	OCCUPATIONAL THERAPY	68.00		
8	05	86	PHYSICAL THERAPY	64.50		
8	05	86	SPEECH PATH AUDIOLOGY	45.00		
8	05	86	PHARMACY	7.65	4.40	

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			FRANCES SMITH	70717	86	

MO.	DAY	YEAR	SERVICE RENDERED	CHARGES	CREDITS	BALANCE
8	05	86	CENTRAL SUPPLY	22.54		
8	05	86	RESPIRATORY THERAPY	8.50		
8	06	86	DAILY CARE	287.00		
8	06	86	OCCUPATIONAL THERAPY	68.00		
8	06	86	PHYSICAL THERAPY	83.00		
8	06	86	SPEECH PATH AUDIOLOGY	45.00		
8	06	86	PHARMACY	7.65		
8	06	86	CENTRAL SUPPLY	32.54		
8	06	86	RESPIRATORY THERAPY	8.50		
8	07	86	DAILY CARE	287.00		
8	07	86	OCCUPATIONAL THERAPY	34.50		
8	07	86	PHYSICAL THERAPY	33.50		
8	07	86	SPEECH PATH AUDIOLOGY	33.50		
8	07	86	PHARMACY	7.65	2.00	
8	07	86	LABORATORY	204.00		
8	07	86	CENTRAL SUPPLY	23.14		
8	07	96	RESPIRATORY THERAPY	8.50		
8	08	86	DAILY CARE	287.00		
8	08	86	OCCUPATIONAL THERAPY	34.50		
8	08	86	PHARMACY	24.45		
8	08	86	CENTRAL SUPPLY	13.50		
8	08	86	RESPIRATORY THERAPY	8.50		
8	09	86	PHARMACY	7.65	2.60	
8	09	86	CENTRAL SUPPLY	12.10		
8	09	86	RESPIRATORY THERAPY	8.50		
8	10	86	PHARMACY	.65		
8	11	86	PHARMACY		16.80	
						14,097.00

YOUR INFORMA
HAS BEEN SU
MEDICARE PAY
AND WILL BE

Senator PRYOR. Before Dale goes, I want to say one thing. He left Calico Rock to come here, and now he's got to go back to the airport and get back on a plane and go to Paragould, so you know that he is committed to this issue. We have discussed this issue many times, and we are very appreciative that Senator Bumpers rescheduled this entire day and went to great trouble in order to be with us here. We are both, I can assure you, searching for answers.

Dale, right before you came, Dr. Busfield handed me a sampling of some hospital bills by some local individuals whose names are scratched out. These people fell through the gap. How would you like to be discharged from a local hospital owing $96,875.09? However would you like to be discharged owing $16,212, a 70-year-old individual?

Senator BUMPERS. We used up all my savings on the first one.

Senator PRYOR. How would you like to be discharged from a local hospital owing $54,420.18; $15,277; $17,990, and on down the line. I think Senator Bumpers and I both know of a small hospital in North Arkansas where several individuals were patients there. They fell through the gap. There was no insurance, not covered by Medicare, Medicaid. This small hospital literally had to eat all of those costs, and almost had to close its doors or raise its room payments or its fees to stay open, because when you sock it to hospitals or individuals with costs like this, we all come out the loser, so we have got a find a true solution to this.

And, Roger, I appreciate you bringing that enlightening information to us.

Senator BUMPERS. Let me make one other point. On behalf of the hospitals, let me say that they are just as concerned about this as Senator Pryor and I are. They make, I think, big efforts to control their costs. They are required to do so by all the Federal regulations. But let me tell you something that is going up in this country that is totally unacceptable. There are 35 million people in this country who have no insurance and who are not eligible even for Medicaid. They fall through the cracks that you've mentioned, David. And on any given day of the year in this country at least 65 million people are uninsured. These people get sick and they have injuries, and they have to go to the hospital. Hospitals admit them, and they know that they aren't going to be paid because the patients are uninsured, absolutely uninsured, so you can see that that is a really gigantic problem in this country.

For a great wealthy rich nation like this to have 35 million people who don't qualify for any kind of health care is devastating to us as a society. Thank you, again.

Let me say, David talked about how dedicated to this issue I am. I'm also dedicated to being reelected, and that's the reason I'm doing all of this, ladies and gentlemen.

Senator PRYOR. Now, you in the audience have a chance to ask these panelists or any of our other panelists, a question or to make a short statement for our public record.

AUDIENCE MEMBER. Senator, earlier you mentioned and Senator Bumpers mentioned an act Secretary Bowen proposed. What is the status of that?

Senator PRYOR. It has just been proposed. This is once again the new Secretary of HHS. The President in his State of the Union Ad-

dress mandated that a 1-year study take place. Next month Secretary Bowen will be giving the President of the United States the results and recommendations of this study, and then I can only assume that the President would transmit to the Congress, the new Congress in January, his recommendations for catastrophic health insurance or a way to deal with this issue. To the best of my knowledge, that's generally the issue. There are also other proposals that will be introduced to deal with catastrophic health problems. For the most part this legislation will be coming through the Senate Finance Committee. We will be very busy looking at these issues.

Another question?

AUDIENCE MEMBER. Senator, according to an Arkansas Association of Retired Persons Modern Maturity I read recently, I believe it stated Medicare, $300 billion worth, was to distribute $77 billion; and I'm wondering if that is a statement of fact, and if in effect Medicare administration can pay $50 billion above one-fourth of the budget of the funds that they are given to the public of the United States.

Senator PRYOR. I'm sorry. Is it administrative cost?

AUDIENCE MEMBER. Yes.

Senator PRYOR. How much is being used?

AUDIENCE MEMBER. An article I read indicated $77 billion out of $300 billion.

Senator PRYOR. You mean administration cost from the $300 billion would be?

AUDIENCE MEMBER. $77——

Senator PRYOR. I understand from Theresa Forster here, who I really must say is an expert in this area, the administrative cost of administration for Medicare is about 1.4 percent for the hospital portion and about 4.3 percent for the supplementary medical insurance. Now, I will certainly check those figures, and if you will leave your name with one of our staff people, we will certainly try to get back to you on that. Modern Maturity, by the way, is a very fine magazine of the AARP. Yes, do we have a question over here?

AUDIENCE MEMBER. Does any Arkansas insurance company consider writing a major catastrophic policy with, for example, a $10,000 or $20,000 deductible?

Senator PRYOR. Maybe Dr. Mitchell of Blue Cross/Blue Shield would be the one to answer this.

Dr. MITCHELL. At the present time in the entire United States—if this is OK to speak from here, sir?

Senator PRYOR. Certainly.

Dr. MITCHELL. There are probably not more than 150,000 people that have a policy like that. We had a test market by a major insurer in about five or six States last fall that would write an indemnity-type custodial nursing home benefit of $40 a day, with the rate varying from $25 up to $100 a month, depending on the age. They test marketed that in about 215,000 households, and in 2 months, only 2,000 people bought it. I can tell you from our standpoint you will see major efforts probably in 15 test States next year to market this other product.

Senator PRYOR. Another question or statement or speech, short in nature?

AUDIENCE MEMBER. May I say something as a present involvement—my wife has just had a stroke. The bill that I received, which fortunately was paid for by Medicaid, was $14,000. I think it was very unreasonable, because I think, without picking on them, that $287 a day is too much money for nothing but a double room. Medicare should investigate that expense. In addition to that, the bill provided $75 for two family conferences. What was it? Excuse me. "Get the hell out of here." That's what it amounted to. Now, let's speak from a medical standpoint. I'm out of there. I have an expense at home of over $500 a week that Medicare does not allow anything for. Now, whether you want to call that catastrophic or not, it adds up to over $20,000 a year. If you can pay for Medicare $287 a day, then it is ridiculous to tell me that some benefits cannot be paid for home care, which I have to pay for, in order for me to stay there at the house with my wife 24 hours a day. And that is a lot cheaper than their $287 a day. Now, if you want the bill, there's the bill. My name and her name are on it. I'm not ashamed of it. You don't have to say the name is scratched out. My name is R.D. Smith, and I live here in Pulaski County. That's all I've got to say, so you should be able to work something for home care.

Senator PRYOR. Mr. Smith, your statement will be made a part of the record and the intensity with which you delivered it will be noted. Thank you very much. That was a nice statement and we appreciate that.

AUDIENCE MEMBER. Do you want this?

Senator PRYOR. Yes. Theresa will come and take that. Thank you very much for this. Yes, sir.

AUDIENCE MEMBER. Senator, we keep talking about people falling though the gap, all this catastrophic expense, and all of these people that are between jobs, no insurance at all. Most of us don't want it to happen, but if we keep going this way and if we don't get something done to get relief on this, we are headed to socialized medicine, and we certainly don't want that.

Senator PRYOR. Amen. I know I don't want it, and I don't think our people want it, really, but we are headed in the wrong way unless we do something pretty quickly. Let's see now. Do you have another statement?

AUDIENCE MEMBER. May I say one thing?

Senator PRYOR. Yes.

AUDIENCE MEMBER. What is the significance of saying that Blue Cross/Blue Shield would become a mutual insurer at the first of the year rather than the hospital medical insurance that they now represent?

Senator PRYOR. George, I don't know that answer. Maybe you do.

Dr. MITCHELL. Does anyone want to hear that? It's rather bothering, but I can tell about it. It's virtually transparent to customers. It has to do with dual regulation that we've had for many, many years. Otherwise, it would be transparent.

Senator PRYOR. Let me thank you for coming to this hearing today, and once again sign the request sheets, and we will have mailed to you, I imagine within about 5 to 6 weeks, the hearing statement and the transcript from this meeting today. None of us know the answers. All of us know that we've got to find some an-

swers and we've got to do it very quickly. And your contributions, especially from our panel, those that asked questions, and those who have honored us by your presence, is appreciated, and we express our gratitude. Thank you very, very much.

[Whereupon, at 3:25 p.m., the committee was adjourned.]

APPENDIX

MATERIAL RELATED TO HEARING

Item 1

HHS NEWS

U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRIVATE/PUBLIC SECTOR ADVISORY COMMITTEE
ON CATASTROPHIC ILLNESS

Final Meeting

August 19, 1986

Otis R. Bowen, M.D.
Secretary of Health and Human Services

Don M. Newman
Under Secretary

Members, PPSAC:

James Balog (Chairperson)
Vice Chairman
Drexel Burnham Lambert
New York, N.Y.

Daniel Bourque
Executive Director
National Committee for Quality Health Care
Washington, D.C.

Michael D. Bromberg
Executive Director
Federation of American Health Systems
Washington, D.C.

Carol McCarthy, Ph.D.
President-designate
American Hospital Association
Chicago, Ill.

James L. Moorefield
President
Health Insurance Association of America
Washington, D.C.

Mrs. Vita R. Ostrander
President
American Association of Retired Persons
Washington, D.C.

Mayor John K. Rafferty
President
New Jersey Conference of Mayors
Trenton, N.J.

William T. Ray
Midwest National Bank
Indianapolis, Ind.

James Sammons, M.D.
Executive Vice President
American Medical Association
Chicago, Ill.

Bernard Tresnowski
President
Blue Cross & Blue Shield Association
Chicago, Ill.

Paul L. Willging, Ph.D.
Executive Vice President
American Health Care Association
Washington, D.C.

The Honorable David Durenberger
United Statess Senate
Washington, D.C.

The Honorable Fortney (Pete) Stark
United States House of Representatives
Washington, D.C.

Members, HHS Executive Advisory Committee on Catastrophic Illness

Thomas R. Burke, Chairman
Joseph R. Antos, Vice Chairman

Ronald F. Docksai
Jean K. Elder, Ph.D. (represented by Carolyn D. Gray)
Dorcas R. Hardy (represented by Louis D. Enoff)
Robert B. Helms, Ph.D.
Richard P. Kusserow (represented by Bryan B. Mitchell)
Stephanie Lee-Miller
S. Anthony McCann
Ronald E. Robertson
William L. Roper (represented by C. Ross Anthony)
Robert E. Windom, M.D.

Steven A. Grossman
Philip M. Jos
Randy L. Teach
Charlene C. Quinn

WORKING DRAFT SUMMARY OF COMMITTEE VIEWS

Statement of Goals

All segments of the American population should have protection from the catastrophic financial consequences of illness. Such expenses not covered by insurance or other sources can overwhelm the finances of individuals and families. While the number affected may be small in relation to the total population, most everyone is at risk, and for the individual or family faced with catastrophic costs the impact can be devastating.

A primary policy goal is to extend coverage where necessary through some combination of private and public sector initiatives. Furthermore, the goal should be to cover all persons for extraordinary expenditures beyond the scope of normal care, when those expenses become catastrophic when compared to financial resources.

Overview

The Committee holds a strong consensus view that insurance or coverage mechanisms can be provided in the most cost effective manner by the private sector and that

government has a special obligation to facilitate private sector solutions. However, government financing of catastrophic health care coverage for certain segments of the population will continue to be necessary.

Furthermore, both private and public sectors have an obligation to enhance consumer education, clarify current health insurance coverage, encourage the purchase of private policies, and promote individual responsibility for health care.

Marketable catastrophic insurance products must be available and affordable, and there must be sufficient incentives for their wide-spread use. The Committee believes that income and financial resources must be considered in designing mechanisms for each group at risk. Financing catastrophic insurance protection based on an individual's ability to pay should be a central tenet of any new initiative. For the poor and many low income persons, additional government resources may be necessary to extend and improve coverage.

Overall, the Committee wishes to emphasize that any major progress measurably to improve access to catastrophic protections for all segments of society will require additional resources from individuals, employers and

government. Simply put, there are no free options that make a major difference.

Definition of Catastrophic Illness

The Committee defines catastrophic illness in terms of financial consequences borne by the individual or family rather than in terms of the type, intensity or duration of a specific illness. The economic consequences of illness become catastrophic if the out-of-pocket expenses of the individual or family, excluding expenses reimbursed by insurance, employers, and government programs, become financially devastating.

Providing Catastrophic Protection

The Committee has addressed the problems of catastrophic coverage as it affects all segments of our society. It has found that the resources available to different groups to cover health care expenses vary substantially. Accordingly, remedies will vary with the shortcomings in coverage and the needs of each group. For purposes of this report, the Committee will address potential solutions under the following categories:

A. Acute catastrophic expenses for persons 65 and over

B. Acute catastrophic expenses for persons under 65

C. Catastrophic long-term health care expenses for all persons.

A. Coverage of acute catastrophic expenses for the over 65 population

Problem: Although the Medicare program and private supplemental insurance (Medigap) policies provide a significant level of protection to the majority of this population, certain individuals remain at risk. The main problems relate to the unlimited nature of cost sharing liabilities in the Medicare program, Medicare benefit limitations, and from the fact that a significant minority of individuals have no additional coverage beyond Medicare.

Objective: The primary objective is to provide catastrophic protection through a combination of public and private sector efforts, for those who remain at risk due to Medicare limitations or lack of additional coverage.

A corollary objective is to expand the scope of catastrophic protection available in the private market.

5

Discussion: The availability and cost of insurance for the over 65 population must be addressed. The Committee received extensive testimony concerning the gaps in coverage for the elderly. However, a structure exists for providing catastrophic protection through existing Medigap insurance policies issued by the private insurance industry, or through the Medicaid program.

Within the private sector, efforts should be intensified to improve protection for catastrophic illness expenses in Medigap policies and to increase the availability of separate catastrophic coverage policies providing various optional coverages.

Adjustments in public programs can also be considered. For example, the current Medicare Part A program does not provide catastrophic protection from long hospital stays or certain other expenses.

All Medicare beneficiaries should have access to adequate and affordable catastrophic protection. This can be accomplished in many ways:

1) Providing for additional benefits to the current Medicare program using premiums and/or cost-sharing limits related to ability to pay;

2) restructuring the current Medicare benefit package on a cost-neutral basis to Medicare to provide 365 days per year of inpatient hospital coverage while maintaining reasonable limits on cost-sharing liabilities;

3) providing for expansion, promotion and adequate payment of alternative health plans for Medicare beneficiaries in a pluralistic delivery system, but maintaining a high level of quality care;

4) providing for the availability of vouchers for the purchase of private insurance policies;

5) studying the need for more effective ways to broaden mental health coverage; and

6) stimulating augmented catastrophic coverage through expanded use of private insurance policies.

Pre-funding mechanisms, including the use of private savings concepts, such as medical IRAs, should be studied as a potential part of the long term solution. While medical IRA mechanisms are not viewed at this time as a cornerstone for financing Medicare, they may reduce the future need to

use general revenues or payroll taxes to fund care and could be used to supplement Medicare coverage.

B. Coverage of acute catastrophic expenses for the general population

Problem: While the majority of Americans with private insurance have protection against the expenses of acute care, many do not have adequate protection when expenses reach catastrophic levels. However, the main problem is the minority who lack private insurance or who are inadequately protected, yet who are ineligible for public coverage. Those who lack catastrophic acute care protection are more likely to be low income persons and their dependents or they are medically uninsurable (either unemployed or employed in low wage jobs).

Objective: For acute catastrophic coverage of the under 65 population, the objective is to encourage those employers with limited or no group health plans to help cover employees and their families, and to cover the remaining population through a combination of public and private programs.

Discussion: Most of this population group is covered through the employment setting. Nevertheless, there remain

significant numbers without protection - basic and/or catastrophic.

Limitations in access to adequate insurance for these groups must be addressed. Some things can be done to expand coverage availability for the under age 65 group, without major governmental resources. In particular, the government can be a facilitator in making private insurance coverage available. Coverage availability must be realistic, i.e., it must be readily available at affordable costs. Extension of catastrophic coverage for the general population would require careful targeting of the uncovered population and the tailoring of a variety of solutions to the particular characteristics of various subgroups, e.g., the medically uninsurable, the uninsured and underinsured in the labor force, and the uninsured not in the labor force.

While the Federal government has taken some steps to make insurance coverage available on a continuation basis in the employment setting where coverage might otherwise be terminated, more can be done. Although, some states have moved to make coverage available through such mechanisms as risk pools for uninsurables, they and the insurance industry have been handicapped by current ERISA restrictions on state regulation of self-insured employer plans. These barriers should be removed.

Policy options should encourage private sector solutions. The following are a list of such options that deserve careful consideration:

1) Amendment of ERISA and/or the tax code to permit states to require equitable universal participation by all insurers, including self-insurers;

2) appropriate tax deductibility of health insurance premiums for the self-employed, sole proprietorships and the employed who provide their own coverage;

3) state risk pools aimed at, but not limited to, uninsurables, with the financing broadly based and equitably distributed (including potential subsidies where private coverage is not available);

4) technical assistance programs to facilitate access to the most affordable health insurance for individuals and small employers; administration could be a combination of federal, state, insurer, or business community responsibility;

5) an income-related voucher for the purchase of insurance against catastrophically high health care costs;

Policy options oriented toward the public sector should also be considered:

1) Guarantees for loans obtained to pay catastrophic health care costs above a threshold that is relative to income;

2) Medicaid restructure:

   a) separation of welfare eligibility and Medicaid eligibility to encourage states to cover the medically indigent in the short term;
   b) mandatory state provision of a Medicaid medically needy program with greater state flexibility concerning coverage and eligibility,
   c) mandatory uniform income threshold levels for Medicaid eligibility,
   d) catastrophic coverage for Medicaid eligibles,
   e) Medicaid expansion to include AFDC families where both parents are in the family unit.

3) an income-related buy-in program where low income persons without employer coverage and not eligible for Medicaid can buy into state risk pools or the Medicaid program;

4) establishment of a separate catastrophic expense fund to be used for catastrophic expenses above some percentage of adjusted gross income of an individual or family.

C. Catastrophic long-term health care expenses for all persons:

Problem: The vast majority of Americans are not protected from catastrophic expenses associated with long term care. Persons of all ages remain at risk for expenses resulting from three types of long-term care services; skilled nursing care, intermediate care, and custodial care. Insurance mechanisms have been developed and are becoming more available to cover the expenses of skilled care. However, insurance products to cover the expenses of intermediate and custodial care, though now being developed, are much less available. This is due to a combination of lack of consumer awareness of risk, confusion over what Medicare covers, lack of employer interest in adding group benefits, actuarial uncertainties, and the availability of what some may view to be "free" Medicaid coverage.

Objective: The objective in developing a coordinated public and private sector approach is to extend and improve coverage against the expenses of long term care by:

1) encouraging individuals and employers to make provisions for long-term care needs through savings, private insurance, and employee benefits programs to the extent possible, permitted by their income, 2) providing access to needed long term care when individual resources are inadequate, and 3) establishing a more humane and rational alternative to the current application of eligibility requirements in the Medicaid program (i.e., spend-down or transfer of assets). The system of public and private coverage should be oriented toward patient need. It should include the potential for a broad range of facility- and community-based services based on patient requirements.

Of special concern to the Committee is that basic family values should be retained and fostered in addressing the long-term care needs of the elderly and the disabled. Stated more affirmatively, family responsibility and participation should be encouraged, with existing disincentives eliminated and incentives created to achieve increased family involvement.

Discussion: The Committee is sympathetic with the oft-repeated views presented to it that economic ruin frequently attends long-term stays in nursing homes. The problem is extremely complex and involves consideration of various

levels of care, such as skilled nursing services, intermediate care, and custodial care. The Committee believes that different approaches may be desirable in addressing these needs, but in all cases, programs intending to provide for skilled health care needs should be separated from programs providing custodial needs.

While persons of all ages are at risk for catastrophic expenses for long-term care, the elderly are particularly vulnerable. The present limitations of Medicare coverage must be examined as a first priority concerning long term care for the elderly. Beneficiary confusion regarding coverage must be dispelled. Medicare coverage expansion should be pursued to the extent feasible. Expanded Medigap coverage should also be encouraged and should offer readily available options beyond the limitations of Medicare coverage. The insurance industry does currently provide broader coverage available in non-Medigap policies.

The disparate Medicaid policies of the various states warrant special examination, including improvements in defining the categorically needy and the medically indigent as affected by varying spend-down policies. Improvements in the Medicaid programs discussed in the previous section are applicable to the discussion here of long-term care.

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The following options deserve careful consideration:

1) Stimulate private and public sector programs to:

   a) educate the public about the need for and the various kinds of long-term care protection,

   b) ensure that state and local governments assume a greater role in public education regarding long-term care coverage and protection;

2) encourage expanded availability of private insurance for long-term skilled nursing services and intermediate care services;

3) promote tax-preferential IRA or other savings arrangements to stimulate the purchase of long-term care insurance to the greatest extent possible;

4) improve data on costs and utilization of long term-care services;

5) encourage practical research and demonstration projects regarding alternatives for providing long term care and for ways of distinguishing levels of long term care need, including different approaches to payment, for example, encouragement of alternatives that combine

financing and delivery, such as social HMOs, life care centers, etc.;

6) remove impediments to employers for providing long-term care insurance, e.g., DEFRA; and

7) clarify the appropriate scope of "skilled nursing services" and "home health services" under Medicare to include a broader range of nursing and other health services.

BASIC PRINCIPLES FOR POLICY FORMULATION

The following are a set of ten basic principles which represent the thoughts of committee members concerning approaches for dealing with the problem of catastrophic medical expenses among all Americans. These principles do not imply a particular solution to the overall problem but are meant instead to serve as guiding themes for evaluation of different policy options by the Secretary.

1. A Shared Public/Private Sector Responsibility:

   Responsibility for catastrophic insurance must be shared between the public and private sectors. Even if a strong private approach is preferred, the public sector must play an important role in stimulating and overseeing these activities. This should be accomplished primarily through incentives rather than mandates. Incentives offer more flexibility and the potential for innovative action, instead of rigid prescription of solutions. Government should not attempt to limit the design of health benefit plans but should monitor the marketplace and assure consumer protection.

2. The Insurance Approach:

   Preferred solutions to the problem of catastrophic medical expenses -- whether they result from acute care or long-term illness -- rest with improved insurance. Spreading the risk of enormous medical expenditures across the population will ease the current burden on the smaller number of Americans who now struggle under the weight of catastrophic expenses, or who forego essential care.

   Any risk pool, to be workable, must be large and should not permit individuals to "fall through the cracks."

3. Catastrophic vs. Basic Benefits:

   Catastrophic coverage should be viewed as an enhancement rather than a replacement for adequate basic protection against the costs of illness and injury. Care must be taken to avoid uncessarily restricting the risk pool, lest costs become prohibitively high.

4. Design of Viable Solutions:

Coverage against catastrophic expenses for the entire population is not susceptible to one simple solution. A combination of actions will be needed all of which, taken together, offer a reasonable solution. Flexibility and diversity should be encouraged. Solutions should be targeted to those not presently protected. Limited government funds should be focused on the needs of low-income individuals. In publicly supported programs, individuals should contribute to their care according to their financial resources and ability to pay.

5. Increased and Secure Funding:

Whatever the specific public and private sector roles in developing approaches, additional funds will be needed to finance the cost of catastrophic coverage. If spread across a large population, comprehensive catastrophic coverage is certainly affordable. Thought must be given to long term security of funding sources when changing current programs or developing new programs

6. Case Management/Utilization Control:

Critical to effective financing is the provision of services within the most cost-effective environment consistent with quality care. Mechanisms to achieve these goals, including case management and utilization control, should be considered and utilized, as appropriate, as part of any overall scheme. Whether implemented by payers, participants in the delivery system itself, or external agencies, there must be assurances that services are being delivered in the setting most efficiently geared to the needs of individual patients.

7. Guarantee Quality Services:

An essential part of any system should include guarantees of quality services, with particular emphasis on patient protection and rights. Preferably this quality assurance system should emphasize a minimal government role. This can be done through oversight programs that appropriately involve all interested parties.

3

8. Support the Informal Care Network:

All insuring mechanisms should be supportive of, and not substitute for, informal networks of care -- which utilize the family. (This particularly applies to long-term care). Specific efforts should be made to assure that the informal network maintain its vitality and viability possibly through direct incentives. Any financing arrangement should create only a system designed to deal with those individuals no longer capable of being handled by the informal network.

9. Flexibility/Competition/Individual Choice:

Considerable flexibility must be allowed in terms of insurance mechanisms, the substitutability of benefits within basic packages, and the enhancements available to individuals above base coverage. The private sector must be allowed to compete within broad parameters above the base. Freedom of individual choice must be preserved.

10. Education and Consumer Awareness:

All approaches for dealing with the problem of catastrophic medical expenses must recognize the importance of an educated public. It is essential that consumer awareness of available insurance coverage be promoted, and that situations which are not covered by current health insurance programs, both public and private, be clarified. This responsibility should be shared by private insurers, government and employers.

Item 2

Mrs. Rosalie Platt
Fort Smith, Ark.

Thank you, Senator Pryor, for the opportunity to be present for such an informational, interesting, factual Senate Hearing. I commend you for your concern and interest in the needs of us "Older Americans"!

Dr. James A. Mitchell
Little Rock, Ark.

I liked the plan presented by the representative of AARP. It's a good start! I appreciate being part of the group carrying on a very worthwhile hearing about a very important subject.

Thank you, David Pryor, for your genuine interest in us;though "old" we like to be contributors in a positive way!

Leah Leonard
Little Rock, Ark.

1. All elderly persons, except those of unlimited resources, need an affordable long term insurance policy, including payment for Medicare.
2. Perhaps one of the most universal desires of the elderly is not to outlive their resources. An affordable reliable long term care policy would go a long way toward solving that problem or relieving that fear.
3. Policies should be understandable.
4. Something should be done to protect the elderly from fraudulent insurance agents.

Sam M. Taylor
Mausfield, Ark.

There is a definite need for some kind of help for those persons experiencing catastrophic health problems.

C. Araoz
Little Rock, Ark.

The resources have not kept up with the expectations of the public for delivery of geriatric health services.

1. Expectations must be trimmed to "realistic" (financial and medical) terms.
2. Resources must be better managed than they were up to now. Putting more in will not prevent future bankruptcy unless the system is changed. Cut administrative costs first. Health care administrative costs expanded more than all others in the past 12 years.
3. We are enduring the problems of a "national-health system" and receiving none of the benefits which the nationalized health care system could give us now and for the future.
4. The administration's proposed "additional charge for all..." is nothing beyond a fair beginning. A lot more is needed without inflationary effects. Inflation is the most pernicious act of governments.

Thank you for your concern.

Elizabeth C. Goodwin
N. Little Rock, Ark.

Just about what has been said here today. We need a program whereby we will be able to provide ourselves protection against a catastrophic illness or nursing home expenses.

Edith L. McCool
Bauxite, Ark.

1. The information requested on government forms is not what they need to know or is lacking.
2. Residents are receiving expensive, unneeded medications.
3. Doctors (some of them) coming to a nursing home, do not see patient or look at patient's chart and yet record the visit was made. (Have seen this recently)
4. Residents have too little room to live or exist maybe.
5. Workers have little or no training and I found administrators wanted no teaching or learning.
6. When in-service director reads to group, all workers sign "I completed such and such in-service training". No practice of procedure and no demonstration of procedure has been completed.
7. Food is barely palatable. Special diets are non-existant.
8. Residents treated with little or no respect.

I am an RN (retired). I have worked in 2 nursing homes and for 3 years at Alexander unit of MRDS.

Mrs. Lorraine Braughton, RN
Bentonville, Ark.

I work for a Home Health Agency and see numerous cases daily in which there is a medical need but due to the inadequacy of the Medicare guidelines we are unable to care for these people.

Many old people have chronic diseases, such as Alzheimers, COPD. These people need a certain amount of medical attention but under the Home Health guidelines these people are not covered.

Many old people are unable to go out very much but being homebound is also another condition for being seen by home health. So there are people who do need the medical attention but because they do not fit the homebound requirement we cannot take care of them.

Intravenous antibiotics are also another item that is not covered under Medicare. Consequently, the patient has to either remain hospitalized for the period of therapy (which can be as much as 8 weeks), thereby costing the government a lot more money, or they have to pay for the therapy themselves, which, in most cases is not affordable to them.

It is very sad to think that people work and pay taxes for so many years and then when they retire their medical coverage is so limited and not enough to meet their needs.

To compound this, many private insurance policies reduce their benefits after age 65. So even if the elderly could afford a supplement policy their coverage is still limited.

Many insurance policies will only pay for what Medicare normally pays for so that still leaves a big gap for the elderly.

Where are the elderly to turn for help?

You had better die by the age of 65 or else you become financially drained if you get sick!

Mrs. Mary Louise T. Davis
N. Little Rock, Ark.

This was a fantastic meeting. So many points were brought out that we need so very much and desire so very much.

Rex T. Sharp
Van Buren, Ark.

American health cost is much too costly. A few days in a hospital can cost thousands of dollars. America is the only nation on earth that bases health care on ability to pay and millions of American are denied proper health care.

I personally believe that the American health industry is robbing the taxpayers and patients blind causing Medicare to keep reducing their benefits to Medicare patients. My wife has had cancer since January '86 and along with the worry about her I also am gradually using up lifetime savings for her doctors and hospital care and medication.

Please Senator, I hope you can solve our health care problems but until the outrageous fees demanded from the medical profession is reduced, I have no hope.

Mrs. I. J. Spitzberg
Little Rock, Ark.

When it only cost $170 for a day at Little Rock hospital, why must you pay the 1st $492 of expenses?

John L. Goodwin
North Little Rock, Ark.

Dewey Landtrip's comments were most constructive. We need to do something; not just talk about it.

Tony Barr
Pine Bluff, Ark.

Being of sound mind and physically able to work a full time job and draw a weekly paycheck, I can understand the hardships that the elderly go through when they are hospitalized for a long period of time. But to be home bound with sickness the costs can be unbearable. Also, the government needs to understand the situation from a business standpoint. It's hard to sell items for less than what it cost the supplier and stay in business. Steps should be taken to help the elderly of this country.

Ralph A. Emiling
Fort Smith, AR

To handle the situation:
1. We must separate Medicare again (and Social Security) from the general operating budget and put it under its own category.
2. Strip Medicare of all the extraneous programs that have been attached to it, and Social Security, and keep it as medical assistance to people over 65. All else belongs, as a general obligation, in the general welfare budget, just as police, the army, etc.
3. Study how Europe handles this. What is good, what is bad, what limits are imposed? Then we could have an empirical framework from which to work. Thank you.

Melanie C. Hart
Little Rock, Ark.

If I had an opportunity to testify before the U.S. Senate Special Committee on Aging on "Health Care for Older Americans; Insuring Against Catastrophic Loss" in Little Rock on August 28, 1986, I would have said:
1. Please give us some plan to control exceptionally high charges by hospitals, nursing homes, and doctor's fees so that people with some assets, Medicare and probably some additional insurance, could exist for a longer time without using up all they have in a few years or months.
2. A plan that would help people stay in their homes, with some outside help, would be more comfortable for the patient, and save everyone a lot of money. The tax incentives which have been proposed for elderly dependents in the home would be a help. Also, day care and visiting nursing care that would be at least partly financed by something.

I am not someone who expects complete Government help, but only relief from unreasonable high charges, and assistance in helping select insurance additions to Medicare that would fill in the gaps not covered.

Louis W. Hart
Little Rock, Ark.

We need information on where to obtain coverage that Medicare does not cover.

We need to know if you are trying to take care of someone at home and have to have help, is this paid for?

Also, if a person has to go to a nursing home and needs custodial or complete care, is this paid for under Medicare? If not, what type of policy would a person need.

I am asking these questions because I am 80 years old and my wife is 75.

Marilyn Ramsey, R.N.
Rogers, Arkansas

"I think the system needs to be changed to help people over 65 more especially with chronic illness and more help for the family so they won't be a patient themselves."